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ABBREVIATIONS USED

ACoS	American College of Surgeons
BVS	Bureau of Vital Statistics
CDC	Centers for Disease Control and Prevention
FIPS	Federal Information Processing Standards
ICD	International Classification of Diseases
ICD-O, ICD-O-1, ICD-O-2	International Classification of Diseases for Oncology, the 1st and 2nd editions, respectively
NAACCR	North American Association of Central Cancer Registries
NPCR	National Program of Cancer Registries of the CDC
PHR	Public Health Region
ROADS	Registry Operations and Data Standards (manual of ACoS)
SEER	Surveillance, Epidemiology, and End Results Program of the National Cancer Institute
TCR	Texas Cancer Registry

The following sources were instrumental in preparing this handbook:

* SEER Program Code Manual
* ROADS Manual
* NAACCR's Standards for Cancer Registries, Volume II, Data Standards and Data Dictionary, Second Edition
* Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, Volume I, Third Edition

NEW, REVISED, OR DELETED DATA ITEMS

New data items have been added to the TCR reporting format based on requirements and recommendations of NAACCR and CDC. These data items will help the TCR better describe the incidence of cancer in Texas.

Double underline has been used where there were substantial changes or revisions dated **8/98**.

Added/Revised fields:

Class of Case divides the data into **analytic** and **non-analytic** categories. **Analytic** means the patient was diagnosed and/or received all or part of their first course of therapy at your facility. **Non-analytic** means the patient was first diagnosed and received all of their first course of treatment at another facility. **Non-analytical** cases should *ONLY* be reported by your facility if there is evidence of *active* cancer *OR* if the patient is receiving *cancer-directed therapy*.

Date of Admit/First Contact is the first admission the patient was in your facility for the diagnosis and/or treatment of this reportable cancer or, if previously diagnosed/treated elsewhere, the date of the first admission to your facility with a diagnosis of **active** cancer. If the patient was never an inpatient, enter the date of the first outpatient visit the patient was seen at your institution for a reportable diagnosis. For "Autopsy Only" cases use the date of death as the admission date. A date **must** be entered into this field.

Middle Name should be recorded if available. If middle name is not available, record the middle initial. Leave blank if unknown.

Census Tract will be calculated by the TCR based on information documented in the street and city fields. Census tract is used to calculate incident rates for geographical areas having population estimates. The US Census Bureau provides population data for census tracts.

Birthplace has been added to help ascertain, confirm ethnicity and for use with special epidemiologic analysis. The SEER Geocodes are used in coding this field. These codes include states within the United States, as well as foreign countries.

During patient matching, place of birth is helpful identification information, and is also useful when reviewing race and ethnicity codes. Place of birth can also be associated with certain cancer rates and outcomes. *Code this field only if the information is documented in the medical record.*

Tumor Size records the size in the largest dimension, or diameter of the **primary tumor**, and is always recorded in millimeters.

Regional Nodes Examined identifies the total number of surgically removed **regional** nodes a pathologist examined. Code 99 if information is unknown or not applicable to the site. Examples include: brain; leukemia; lymphoma (nodal); multiple myeloma; patient was treated with radiation, chemotherapy, hormone therapy, or immunotherapy before surgery; reticuloendotheliosis; Letterer-Siwe's disease; and unknown primaries.

New, Revised, or Deleted Data Items, continued

Regional Nodes Positive identifies the number of surgically removed **regional** nodes examined by a pathologist and reported as containing tumor. The number of regional nodes positive can not exceed the number of regional nodes examined. Code 99 if information is unknown or not applicable to the site. Examples include: brain; leukemia; lymphoma (nodal); multiple myeloma; patient was treated with radiation, chemotherapy, hormone therapy, or immunotherapy before surgery; reticuloendotheliosis; Letterer-Siwe's disease; and unknown primaries.

Non Cancer Directed Surgery is a diagnostic procedure. The TCR no longer requires that these procedures be coded, however, in the absence of both surgical procedures of the primary site and regional and/or distant sites, **documentation** of these procedures is still **highly recommended.**

***Surgery Codes* in Appendix G of the July 1996 Cancer Reporting Handbook must be used by state reporting facilities in reporting cases prior to 1998.**

Surgery of Primary Site Codes to be used starting with 1998 cases are different from the surgery codes in the July 1996 Cancer Reporting Handbook. The new cancer-directed surgery codes have been separated into two separate categories. A two digit code will be used for surgery of the primary site and a one digit code for surgery of other regional site(s), distant site(s) or distant lymph node(s). Cancer-directed surgery modifies, controls, removes, or destroys proliferating cancer tissue.

Surgery Of Other Regional Site(s), Distant Site(s) Or Distant Lymph Node(s) describes the removal of tissue(s) or organ(s) other than the primary tumor or organ of origin. This is a one digit code. **Do not** code the removal of regional lymph nodes in this field.

Reason for No Surgery; Radiation; Chemotherapy; Hormone Therapy (optional data set) indicates the reason the patient did not receive cancer-directed surgery, radiation, chemotherapy, or hormone therapy, i.e., not recommended, contraindicated, refused, etc.

Date of Last Contact or Date of Death is the date the patient was last seen at your institution or the date of death. Record the month, day, and year of the date of last contact or the date of death if the patient is known to be deceased.

Vital Status Code the patient's vital status (i.e., alive or expired) as of the date recorded in the "Date of Last Contact or Death". Use the most accurate information available.

Cause of Death should be the underlying cause of death. Central registries are the primary users of this data item. Use the underlying cause of death (ICD-9 code) identified by the Texas Department of Health, Bureau of Vital Statistics.

Deleted Fields:

The TCR no longer requires reporting of AJCC/TNM Stage. If you have an ACoS approved cancer program, you must follow their requirements regarding AJCC/TNM staging in order to keep your approval status.

New, Revised, or Deleted Data Items, continued

Other Changes:

Other changes to this handbook include clarification of rules for existing reportable items and revision of the multiple primary section.

Text documentation to support the codes provided or sufficient documentation from which to code is reportable and **highly recommended** and is vital in our efforts to perform quality assurance to insure the reliability, completeness, and comparability of data. Documentation from state reporting facilities without approved cancer programs enables us to code the morphology, topography, staging, and treatment information to complete the submitted reports. Text information to support cancer diagnosis, stage, and treatment codes should be provided by facilities without a *documented data quality program* such as one approved by the American College of Surgeons.

Surgery codes pages 29, 40, 45 and 48 were modified to reflect TCR reporting guidelines.

NOTE: A star (★) is used throughout the TCR Cancer Reporting handbook to indicate new data items and areas where substantial changes or revisions were made.

INTRODUCTION

Texas Cancer Registry

In 1996, almost 32,000 Texans died from cancer and approximately 75,000 Texans developed a new cancer. The data submitted by cancer reporters and maintained by the TCR is a vital part of efforts to reduce the burden of cancer in Texas.

With authorization from the Texas Cancer Control Act of 1979 and its 1997 amendment, the Texas Cancer Incidence Reporting Act *(Appendix A)*, the TCR collects required information on each patient with a reportable disease seeking diagnosis and/or treatment at a hospital, clinical laboratory, or cancer treatment center within the State of Texas. Chapter 91 of the Texas Administrative Code outlines the rules necessary to implement this act.

The TCR is a population-based cancer incidence reporting system that collects, analyzes and disseminates information on all new cases of cancer. This central repository of information is a valuable and essential tool in the identification of populations at high risk for cancer, the monitoring of cancer incidence trends, the facilitation of studies related to cancer prevention, the evaluation of cancer control initiatives, the planning of health care delivery systems and the development of educational awareness programs.

The contents of this manual are based on the guidelines and standards for cancer reporting established by CDC, NAACCR, SEER, and ACoS.

Compliance

Beginning in 1998, the TCR will begin a more systematic approach to monitoring compliance with the Texas Cancer Incidence Reporting Act. Your regional program will monitor submissions from your facility monthly. If no submissions have been received, a reminder letter will be mailed to your institution. If no submissions are received for any given quarter, a copy of the letter mailed to your attention will also be forwarded to the administrator of your facility.

Because CDC requires timely submissions (abstracts submitted within 6 months of diagnosis), the TCR recommends monthly submissions. At the very least, submissions should be quarterly.

Questions regarding your facilities compliance should be directed to your region's cancer program manager (page 6).

STANDARDS FOR CONFIDENTIALITY, DISCLOSURE OF DATA, AND QUALITY ASSURANCE

Confidentiality

Data obtained under the Texas Cancer Incidence Reporting Act are for the confidential use of the Texas Department of Health and the persons or public or private entities that the Board of Health determines are necessary to carry out the interest of the Act. The data are privileged and may not be divulged or made public in a manner that discloses the identity of the patient. All reporting entities that comply with the Act are immune from liability for furnishing the required information.

Disclosure of Data

All data reported to the TCR are available for use in aggregate form for analysis by registry staff and authorized researchers. Reports of the incidence, prevalence, and survival associated with the state's cancer experience can be generated. Public access to aggregate data is available through published reports or through the TCR, if in accordance with its data release policies and procedures.

The TCR **may** exchange patient-specific data with the reporting facility, any other cancer-control agency, or clinical facility for the purpose of obtaining information necessary to complete an abstract or follow-up information, provided these agencies and facilities comply with the TCR's confidentiality policies. However, without specific written hospital consent, no hospital-specific patient information can be released. The TCR can contact the facility where the patient was seen and obtain written consent to release information.

To achieve complete case ascertainment, the TCR **may** exchange patient-specific data with other state cancer registries if reciprocal data sharing agreements and confidentiality provisions are implemented.

The TCR **may** grant researchers access to confidential information concerning individual cancer patients, provided those researchers comply with the provisions and confidentiality policies mandated by the Texas Department of Health's Committee on Requests for Personal Data.

Quality Assurance

The TCR has an elaborate series of quality assurance procedures that were developed based on the SEER Program, CDC recommendations and which closely follow most NAACCR standards. These procedures, which consist of both internal and external processes, insure the reliability, completeness, consistency and comparability of TCR data.

The internal process includes a review of each hard copy abstract for multiple primaries, duplicate records, and valid codes for each field. As data are uploaded into the system, it is intensely scrutinized for identification of:

- possible duplicate submission of existing records;
- unacceptable codes for any field or interfield inconsistencies; and
- invalid or unusual site/sex, age/site, age/morphology or site/morphology combinations.

Quality Assurance, continued

The TCR is currently working on upload procedures which will check submitted records for errors. Any submission in which there are more than an acceptable percent of errors will be returned to the institution for correction and re-submission. If records are returned to your facility for correction, they will not count towards your compliance.

The external process includes:

- hospital training;
- on-site casefinding studies;
- reabstracting studies; and
- death clearance.

Hospital training includes the continuing education and training of cancer registrars as well as medical records personnel on standards and procedures for reporting. Requests for training and technical assistance should be directed to your appropriate regional program.

Casefinding includes the TCR's on-site review of casefinding sources such as hospital disease indices, pathology reports (including cytology and autopsy reports), outpatient records and appropriate oncology logs for missing cases.

Reabstracting studies involve the complete reabstracting of a sample of reported cases without reference to the original abstract. Discrepancies are identified and used to assess the quality of the hospital's cancer case reporting and training needs.

Death clearance is an additional check of reporting completeness. Each year the data management section of the TCR will match existing incidence cases against the BVS death certificates. If a match is found, the date of death will be updated for that record in the TCR database. Hospitals will be queried on cases in which a report was not received. An abstract must be submitted for all missed cases. In some instances, there may not be evidence of active cancer. If there is no documented evidence of a reportable diagnosis, please inform your program manager in order for a Death Certificate Only case to be created.

INFORMATION NEEDED FOR REPORTING

Reporting Formats

Cancer cases may be reported using one of the five following formats. Submissions should be accompanied by a **Texas Cancer Registry Transmittal Form (TCR #2)**. Please refer to *Appendix B* for instructions on completing this form.

1. Confidential Cancer Incidence Reporting Form (TCR #1): The Confidential Cancer Incidence Reporting Form (TCR #1 revised December 1997) is one format that may be used to report your cancer cases. Examples of completed abstracts are shown in *Appendix C*. It is recommended that an alphabetic file of the reported cases be maintained by **your facility** in order to prevent duplicate case reporting.

   *NOTE: The revised confidential cancer incidence reporting form MUST be used for **ALL** 1998 cases.*

2. SANDCRAB Lite (SCL): SCL, a cancer abstract reporting software developed for non-electronic reporters, is available free of charge. Paper abstract forms are eliminated since cases are entered directly into the computer and submitted to the TCR on diskette. SCL meets TCR reporting requirements but does not meet all ACoS requirements for a cancer program. Contact the System Support Specialist at the Central Office in Austin at 1/800-252-8059 or 512/467-2239 to get your copy of the SCL software or if you have questions regarding the software.

3. Floppy Disk Specifications: Data must be PC-DOS or MS-DOS compatible in non-delimited ASCII format. The following IBM compatible floppy formats are supported:

   - 1.2mb floppy disks - 5 1/4" (i.e. high density PC/AT)
   - 1.44 mb floppy disks - 3 1/2" (this format is preferred)

   NOTE: *Double sided/Double density 360K and 720K floppy diskettes are **not** acceptable.*

4. Magnetic Tape Specifications: The standard tape format is 9 track, 1600 BPI-EBCDIC, unblocked and unlabeled. (The reel should be labeled with a return address.)

   - record size: 5300 characters
   - blocking factor: 5300 characters
   - blocking type: fixed length

5. Computer Modem: Contact the Database Administrator in the Central Office in Austin at 1/800-252-8059 or 512/467-2239 for details on submitting by computer modem. Individual arrangements must be made for modem transmissions.

Format Standards

The layout and coding scheme for Reporting Formats 2-5 should follow the NAACCR's Data Exchange Record Layout. Please refer to the NAACCR's Standard's for Cancer Registries - Volume I, for a description of the layout. All columns without data must be blank.

★ The NAACCR 6.0 version will be required for 1998 cases. This version will be consistent with national cancer reporting standards including the new surgery codes for 1998 cases. All years of data can be submitted in this format and this will eliminate the necessity for record conversions. If necessary, cases diagnosed prior to 1998 may continue to be submitted in the NAACCR 5.1 version. Submissions in an incorrect format, with missing or incomplete data, or with an unacceptable level of errors will be returned to the reporting facility. If cases are returned to your institution, they will not count towards your compliance.

> ***NOTE:*** *When using vendor software packages, follow the coding instructions specific to that software. Do not mix codes, e.g., using county codes from Appendix D from the handbook in place of codes specified in the software instructions. Any alteration or deviation from the codes specified in the software instructions will create errors in reporting. For questions regarding coding, call your appropriate TCR regional staff.*

Each floppy diskette submitted **must** have a **label** affixed with the following:

- name of reporting institution;
- count of the cases included;
- reporting period;
- software utilized (i.e., CANSUR/FACS, CNET^2, MRS, ERS, ELM, ONCO, SCL); and
- format type (1.2 MB, 1.44 MB).

Acceptance of Electronic Data

To assess compatibility of new tape or disk submissions, a test file containing at least 50 records must be forwarded to the TCR. After evaluation of the file, the reporting institution will receive notification of the results. If compatibility is assured, please call the TCR to set up a schedule for regular automated submissions.

Timeliness of Data Submission

Collecting timely cancer data is an important function of the TCR. Researchers, epidemiologists, health planners, clinicians, and lay persons benefit from speedy access to the most current information. Given the current state of patient medical records and the **reporting requirements** of CDC, the TCR requires all cancer cases be submitted to the TCR within ***six months*** **of the initial diagnosis date**, or if diagnosed elsewhere, ***six months*** **from the date of admission**.

Although timeliness of reporting is important, data quality and completeness should not suffer. Training on appropriate reporting procedures will be provided through your regional office as needed.

Data Submission Procedures

Submissions of data (paper forms or electronic) to the TCR should be *monthly, bi-monthly*, or, *at the very least, quarterly*, depending on the size of your institution and caseload. Contact your regional program manager to arrange quarterly submissions. ALL submissions should include a completed **Transmittal Form** (refer to *Appendix B* for instructions in completing the transmittal form) specifying the hospital name, address, date of submission and number of cases being reported per year.

Reporting forms should be batched by year of admission and mailed to the appropriate TCR PHR office. The forms should be mailed in **sealed, double** envelopes marked **CONFIDENTIAL**.

> ***NOTE:*** *To protect patient confidentiality and to avoid forms/diskettes being lost in the mail, it is **strongly recommended** that **any** confidential information being mailed to the TCR be mailed via registered or certified mail. The TCR will also use registered or certified mail to send confidential information to reporting institutions.*

All hospitals reporting **electronically** must send **diskettes** or **tapes** to the **Central Office** in **Austin**. The diskettes or tapes, along with a transmittal form, must be mailed in mailers appropriate for electronic media and marked **CONFIDENTIAL**.

★ For hospitals who have an approved cancer program with the ACoS Commission on Cancer, the ROADS manual as well as the TCR's Cancer Reporting Handbook should be utilized to assure reporting compliance with both entities. For example, the data sets for the TCR and ACoS are different. Please refer to *Appendix L* for a comparison of data sets for the ACoS, NAACCR, SEER, and the TCR.

Please submit your data to the appropriate address as determined by the location of your institution. A map of the PHRs is located in *Appendix E*.

<table>
<tr>
<td><u>Public Health Regions 1,9,10</u>
Pat Ploegsma, RRA, CTR
Program Manager
Texas Department of Health
Cancer Registry Division
Public Health Region 1
1109 Kemper
Lubbock, Texas 79403
806/744-3577
Fax # 806/767-0420
Email: pat.ploegsma@tdh.state.tx.us</td>
<td><u>Public Health Regions 5,6</u>
Judy Spong, MS
Program Manager
Texas Department of Health
Cancer Registry Division
Public Health Region 6
5425 Polk Street
Houston, Texas 77023-1497
713/767-3180
Fax # 713/767-3193
Email: judy.spong@tdh.state.tx.us</td>
<td rowspan="2"><u>Central Office*</u>
<u>Public Health Region 7</u>
Annette Vandewerken
Texas Department of Health
Cancer Registry Division
1100 W. 49th Street
Austin, Texas 78756
512/467-2239 or 1/800-252-8059
Fax # 512/467-8507
Email:
annette.vandewerken@tdh.state.tx.us

*ALL electronic submissions must be sent to the Central Office.</td>
</tr>
<tr>
<td><u>Public Health Regions 2,3,4</u>
Elaine Allgood
Program Manager
Texas Department of Health
Cancer Registry Division
Public Health Region 3
PO Box 181869
Arlington, Texas 76096
817/264-4479
Fax # 817/264-4040
Email: elaine.allgood@tdh.state.tx.us</td>
<td><u>Public Health Regions 8,11</u>
Kathryn Woehler, MPH, CTR
Program Manager
Texas Department of Health
Cancer Registry Division
Public Health Region 8
7430 Louis Pasteur Drive
San Antonio, Tx 78229
210/949-2165
Fax # 210/949-2058
Email:
kathryn.woehler@tdh.state.tx.us</td>
</tr>
</table>

Casefinding and Reportable List

The Texas Cancer Incidence Reporting Act (Chapter 82, Health and Safety Code) requires every general and special hospital, clinical laboratory, and cancer treatment center to submit an abstract for each reportable diagnosis. Every **inpatient** or **outpatient** case with active disease or receiving cancer-directed therapy must be reported to the Texas Department of Health **regardless of the state of residence**.

A disease index should be run, which includes both inpatient and outpatient cases, after records for a given time period are complete and coded (i.e., monthly or quarterly). This list should be checked against a list of patients previously reported to the TCR looking for new cases. An abstract should be completed for patients found on the disease index who have not previously been reported to the TCR. Patients who have been previously reported to the TCR need to be checked for a possible multiple primary. Please refer to the *Criteria for Determining Multiple Primaries* in *Appendix G* for assistance.

> ***NOTE:*** *For institutions reporting by SCL and forms, contact your TCR regional program for an up-to-date listing of cases you have reported.*

Other department logs/records (radiation therapy logs, oncology unit records, etc.) should be reviewed in the same manner as the disease index to assure all reportable cases are submitted to the TCR.

Pathology reports, including all histology, cytology, hematology and autopsy reports, should be reviewed to pick up reportable neoplasms. These should also be reviewed against a list of records submitted to the TCR to avoid reporting duplicates. Be sure to check for multiple primaries if you find a patient was previously submitted to the TCR.

Admissions from a disease index with the following ICD-9-CM discharge diagnosis codes should be checked for reportability:

042	HIV & AIDS (reportable only with a reportable neoplasm)
140.0-208.9	Malignant Neoplasms
225.0-225.9	Benign & Borderline Neoplasms of Brain & Central Nervous System
230.0-234.9	Carcinoma In Situ
235.0-237.6, 238.1-238.3	Carcinoid, NOS (excluding appendix, unless stated to be malignant)
236.2	Cystadenomas of **borderline malignancy or malignant** of ovary
238.6	Plasmacytomas
238.7	Acute panmyelosis
273.2	Alpha/Gamma heavy chain disease
273.3	Waldenstrom's Macroglobulinemia
289.8	Myelofibrosis (only "acute" is reportable)

Admissions with the following treatment codes also should be checked for reportability:

V07.3	Other prophylactic chemotherapy
V07.8	Other specified prophylactic measures
V58.0	Radiotherapy sessions
V58.1	Maintenance chemotherapy

Casefinding and Reportable List, continued

All cases with a behavior code of "2" or "3" in the *ICD-O-2* are reportable neoplasms. Neoplasms of the brain and central nervous system with behavior codes of "0" or "1" also **are** reportable.

The following are **exclusions**:

8000-8004 Neoplasms, malignant, NOS of the skin (ICD-9CM: 173.0-.9; ICD-O: C44.0-.9)
80102 Carcinoma in-situ of the cervix (regardless of histology) (ICD-9-CM: 233.1; ICD-O: C53.0-1, C53.8-9) **beginning with 1996 cases**.
8010-8045 Epithelial carcinomas of the skin (ICD-9CM: 173.0-.9; ICD-O: C44.0-.9)
8050-8082 Papillary & squamous cell carcinomas of the skin (ICD-9CM: 173.0-.9; ICD-O: C44.0-.9)
80772 Intraepithelial neoplasia, grade III of cervix (CIN), vulva (VIN), and vagina (VAIN) (ICD-9-CM: 233.1, 233.3; ICD-O: C53.0-1, C53.8-9, C51.9, C52.9) **beginning with 1996 cases**.
8090-8110 Basal cell carcinomas of any site **except genital sites ***
Note: Prostatic Intraepithelial neoplasia is not reportable (ICD-9: 233.4).

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*Malignant neoplasms for the skin of genital sites **are** reportable. These include: vagina, clitoris, vulva, prepuce, penis, and scrotum (ICD-9CM: 184.0, 184.3-.4, 187.1-.4, 187.7; ICD-0: C51.0-51.9, C52.9, C60.0, C60.9, C63.2).

Cases in which the disease is **no longer active** (i.e., leukemia in remission) should only be reported if the patient is still receiving cancer-directed therapy.

For a diagnosis that uses ambiguous terms, the following guidelines should be used:

The ambiguous terms "*apparently*", "*appears to*", "*comparable with*", "*compatible with*", "*consistent with*", "*favor*", "*malignant appearing*", "*most likely*", "*presumed*", "*probable*", "*suspect(ed)*", "*suspicious*", and "*typical (of/for)*" **are** considered to be diagnostic of cancer.

The ambiguous terms "*approaching*", "*equivocal*", "*maybe*", "*possible*", "*questionable*", "*rule out*", "*suggests*", "*very close to*", and "*worrisome*" **are not** considered to be diagnostic of cancer. Report these cases **only** if cancer-directed therapy is planned or given.

When phrases such as "strongly suggestive" or "highly suggestive" are used, disregard the modifier "-ly" and refer to the guidelines above regarding the primary term.

Additional Guidelines for Case Reporting

Patients with a history of cancer, with no evidence of active disease, should **not** be reported unless they are receiving cancer-directed therapy.

EXAMPLES: *A patient is admitted for evaluation of congestive heart failure who had a mastectomy for breast cancer 8 years ago with no evidence of recurrent or metastatic disease. This patient has no evidence of **active** cancer and should not be reported.*

Additional Guidelines for Case Reporting

A patient was diagnosed with adenocarcinoma of the stomach in 1985 with no evidence of recurrent or metastatic disease. In 1997, the patient was admitted and diagnosed with small cell carcinoma of the lung. Report only the lung cancer, since the stomach cancer is ***not active****.*

A patient was diagnosed 6 months ago with acute myelocytic leukemia, now in remission, on a maintenance dose of chemotherapy. The patient was admitted for evaluation of neutropenia following their last course of chemotherapy. If this is the first admission to your facility, this patient should be reported because they are receiving cancer-directed treatment (chemotherapy).

Cases which were diagnosed and/or treated for cancer prior to admission to the reporting institution **should be reported** if there is evidence that the patient still has **active disease**, whether or not diagnostic or therapeutic procedures were performed in the reporting institution.

EXAMPLE: *A patient is admitted to your hospital with an acute cerebrovascular accident. The H&P states the patient was diagnosed with metastatic lung cancer 4 months prior to admission. He was treated with palliative care and referred to the Hospice program. All indications are that this patient still has active cancer and should be reported to the TCR, regardless of whether diagnostic or therapeutic procedures were performed at your institution.*

Cases diagnosed at autopsy, with no suspicion prior to death that the cancer existed, should be reported.

Cases should be abstracted using the medical record from the first admission (inpatient or outpatient) to your facility with a reportable diagnosis. Information from subsequent admissions may be used to supplement documentation as needed and appropriate.

Do not complete a form for each admission; only one per primary tumor.

EXAMPLES: *A patient is diagnosed with prostate cancer and has several admissions for treatment of the prostate cancer. Only one form should be completed.*

A patient is diagnosed with two separate PRIMARY tumors, such as adenocarcinoma of the prostate and squamous cell carcinoma of the lung. Complete one form for the prostate primary and another for the lung.

CODING INSTRUCTIONS FOR CONFIDENTIAL CANCER REPORTING FORM

Please use **black ink** only and **print legibly** or **type** when completing the Confidential Cancer Reporting Form. Some of the instructions in this section apply only to reporting institutions with a cancer registry.

PUNCTUATION (DASHES, SLASHES, COMMAS, PERIODS, ETC.)
ARE *NOT* ALLOWED IN ANY CODED OR DATE FIELD.

REGISTRY NUMBER (Position 1-6)

To be completed only by institutions with a **cancer registry** that maintain an accession register or **SANDCRAB Lite (SCL) users**. The TCR will code this position for institutions using reporting forms.

A registry number is a unique number assigned to identify the patient. The first two digits identify the calendar year of admission the patient was first seen at the institution for a reportable diagnosis. The following four digits identify the numerical order in which the case was entered into the registry. Each year's accession number will start with **0001**.

> ***EXAMPLE:*** *980001 would indicate the first 1998 case reported from an institution. The registry number, for each individual patient, remains the same for each primary reported by your institution.*

For institutions using SCL, cases are automatically assigned a registry number according to the year of admission at the reporting institution.

> ***NOTE:*** *If a facility starts using SCL in the middle of the year, they should contact their regional program for the appropriate registry number to start with. This will alleviate duplicate registry numbers being assigned to different patients.*

TUMOR RECORD NUMBER (Position 7-8)

This item should be completed only by institutions with a **cancer registry** that maintain an accession register or **SCL users**. The TCR will code this item for institutions submitting a paper reporting form.

For institutions completing this field, 01 should be used for the first primary reported from your facility. This will **only** change if the patient has more than one primary site reported from your facility. Each additional primary will be given the same registry number, and assigned the next highest tumor record number. This position refers to the order in which this primary tumor occurred in reference to others reported by **your institution** after the registry's reference date. The codes are:

01 - First Primary
02 - Second Primary
03 - Third Primary
04 - Fourth Primary
99 - Unspecified Number

Coding Instructions for Confidential Cancer Reporting Form, continued

REPORTING INSTITUTION NUMBER (Position 9-14)

Enter the three (3) digit institution number assigned by the TCR. If you do not know your reporting institution number, contact your regional program or the central office in Austin at (512) 467-2239 or 1/800-252-8059.

REPORTING SOURCE (Position 15)

Enter the code for the source of the documents used to abstract the case being reported. The codes are:

1 Hospital Inpatient/Outpatient or Clinic
3 Laboratory Only (Hospital or Private)
4 Physician's Office/Private Medical Practitioner (LMD)
5 Nursing/Convalescent Home/Hospice
6 Autopsy Only
7 Death Certificate Only

NOTE: *Coding is hierarchical. Within codes 1-5, assign codes in the following priority: 1, 4, 5, 3.*

MEDICAL RECORD NUMBER (Position 16-25)

Enter the ten digit medical record number (MRN) used to identify the patient's first admission with a diagnosis of cancer. MRNs with less than 10 digits and alpha characters are acceptable. If a number is not available (e.g., some outpatient clinic charts), leave blank and specify "OP" in the field.

Special codes:

UNK Medical Record Number Unknown
RT Radiation Therapy department patient without a medical record number
SU One-day surgery clinic patient without a medical record number

★ **CLASS OF CASE** (Position 26)

Class of case divides the data into analytic and non-analytic categories.

Analytical cases (cases 0, 1, 2, and 6) are patients who were diagnosed and/or received all or part of their first course of treatment at the reporting facility or in a staff physician's office of the reporting facility. These cases are included in treatment and survival statistics.

Non-analytical cases (cases 3, 4, 5, 8, and 9) are patients who were diagnosed and received all of their first course of treatment at another facility, OR cases which were diagnosed and/or received all or part of the first course of treatment at the reporting facility prior to the registry's reference date. These cases are not usually included in routine treatment and survival statistics.

Coding Instructions for Confidential Cancer Reporting Form, continued

Codes and definitions:

0 - First diagnosed at the reporting institution and treated elsewhere. Cases include:
- Patients who choose to be treated elsewhere.
- Patients referred elsewhere for treatment due to lack of special equipment; proximity of a patient's residence to the treatment center; financial, social or rehabilitative considerations, etc.

1 - First diagnosed at the reporting institution and had all or part of the first course of treatment at the reporting institution. They also fulfill one of the following treatment situations:
- Patient received all or part of his or her first course of treatment at the reporting institution.
- Patient refused any therapy.
- Patient was untreatable because of age, advanced disease, or other medical conditions.
- Specific therapy was recommended but not received at the reporting institution and it is unknown if therapy was ever administered.
- It is unknown if therapy was recommended or administered.
- Patient diagnosed at the reporting institution prior to the registry's reference date, all or part of the first course of treatment received at the reporting institution after the registry's reference date.
- Patient first diagnosed and had staging workup at the reporting institution and all or part of the first course of treatment was received at a staff physician's office.
- Patient diagnosed in a staff physician's office and then treated at the reporting institution.
- Patient diagnosed and treatment plan developed and documented at the reporting institution. Therapy was delivered elsewhere in accordance with the treatment plan.

2 - First diagnosed elsewhere and treatment plan developed and documented and/or the first course of treatment given at the reporting institution after the registry's reference date. They also fulfill one of the following treatment situations:
- The reporting institution administered part or all of the first course of treatment.
- The reporting institution developed and documented a treatment plan or made the management decisions.

3 - First diagnosed and all of the first course of treatment elsewhere. They are seen at the reporting institution for additional therapy or management, and have active disease. This includes:
- No information is available on the patient's first course of treatment, the patient is now treated or managed at the reporting institution.
- The reporting institution is treating or managing the recurrence, progression, or subsequent treatment of a previously diagnosed malignancy.

4 - Patients who were first diagnosed and received their first course of therapy at the reporting institution BEFORE the registry's reference date. The reporting institution manages or treats a recurrence or progression of that cancer AFTER the registry's reference date.
- Assign a class 4 also if it is unknown whether the reporting institution delivered the first course of treatment.

5 - First diagnosed at autopsy. There was NO suspicion of cancer before the autopsy.

6 - Patients who were first diagnosed and received all of their first course of treatment in a staff physician's office.

8 - Diagnosis established only by death certificate. This class should be used solely by central registries for death certificate only cases.

9 - Also used only by a central registry and includes: unknown if previously diagnosed or treated; and previously diagnosed, date unknown.

Coding Instructions for Confidential Cancer Reporting Form, continued

★ **DATE OF ADMIT/FIRST CONTACT (MMDDYYYY)** (Position 27-34)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Enter the date (month, day, century and year) of first admission to your facility for diagnosis and/or treatment of this reportable cancer or, if previously diagnosed/treated elsewhere, the date of the first admission to your facility with a diagnosis of **active** cancer. A date **must** be entered in this field. If the patient was never an inpatient, enter the date of the first outpatient visit the patient was seen at your institution for a reportable diagnosis. For "Autopsy Only" cases use the date of death as the admission date.

EXAMPLE: *01221997*

★ **LAST NAME** (Position 35-59)

Enter the last name of the patient in **CAPITAL LETTERS**. Hyphens, spaces, and other special characters are **not** allowed.

SUFFIX (Position 60-62)

Enter Jr, Sr, II, etc. Leave blank if not applicable.

FIRST NAME (Position 63-76)

Enter the first name of the patient. Hyphens, other special characters and spaces are **not** allowed in this field.

ALIAS (Position 77-91)

Enter an alternate name or "AKA" used by the patient. Leave blank if not applicable.

★ **MIDDLE NAME** (Position 92-105)

Enter the middle name of the patient. If middle name is not available, record the middle initial. Leave blank if unknown.

★ **MAIDEN NAME** (Position 106-120)

Enter the maiden name of the patient. Hyphens, spaces, and other special characters are **not** allowed. This field is important to help verify ethnicity.

Coding Instructions for Confidential Cancer Reporting Form, continued

STREET ADDRESS (Position 121-145)

Enter the number and street or the rural mailing address of the patient's residence at time of admission **in 25 characters or less**. Punctuation marks are **not** allowed in this field.

If the address contains more than 25 characters, omit the least important elements, such as the apartment or space number. Do not omit elements needed to locate the address in a census tract, such as house number, street, direction or quadrant, and street type.

Abbreviate as needed, using standard address abbreviations listed in the *U.S. Postal Service National Zip Code and Post Office Directory* published by the U.S. Postal Service.

If the medical record has **no patient address**, enter **NO ADDRESS** or **UNKNOWN. DO *NOT* LEAVE BLANK**.

EXAMPLE: *1232 Southwest Independence Apartment 400*

ENTER AS: *1232 SW Independence 400*

CITY (Position 146-165)

Enter the city of residence at time of admission. If the medical record has **no patient address**, enter the city in which ***your institution*** is located.

STATE (Position 166-167)

Enter the appropriate **two letter abbreviation** for state of residence at the time of admission. If resident of foreign country, enter the appropriate two letter abbreviation for country of residence at admission. If abbreviation for a particular **foreign country** is ***NOT*** listed below**,** enter **"FC"**. If the medical record has **no patient address,** enter the state in which ***your institution*** is located. The codes are:

AL	Alabama	IL	Illinois	MT	Montana	RI	Rhode Island
AK	Alaska	IN	Indiana	NE	Nebraska	SC	South Carolina
AZ	Arizona	IA	Iowa	NV	Nevada	SD	South Dakota
AR	Arkansas	KS	Kansas	NH	New Hampshire	TN	Tennessee
CA	California	KY	Kentucky	NJ	New Jersey	TX	Texas
CO	Colorado	LA	Louisiana	NM	New Mexico	UT	Utah
CT	Connecticut	ME	Maine	NY	New York	VT	Vermont
DE	Delaware	MD	Maryland	NC	North Carolina	VA	Virginia
DC	District of Columbia	MA	Massachusetts	ND	North Dakota	WA	Washington
FL	Florida	MI	Michigan	OH	Ohio	WV	West Virginia
GA	Georgia	MN	Minnesota	OK	Oklahoma	WI	Wisconsin
HI	Hawaii	MS	Mississippi	OR	Oregon	WY	Wyoming
ID	Idaho	MO	Missouri	PA	Pennsylvania		
CN	Canada	MX	Mexico	FC	Foreign Country		

Coding Instructions for Confidential Cancer Reporting Form, continued

ZIP CODE (Position 168-176)

Enter patient's zip code at time of admission. If known, enter nine digit extended zip code. If zip code is not available, refer to the National Zip Code Directory. If resident of foreign country, record "88888" for the zip code. If the medical record has no address, enter the zip code of your institution. If recording the full nine digit zip code, no dash should be placed between the first five and the last four digits.

FIPS COUNTY CODE (Position 177-179)

Enter the appropriate three digit code for the Texas county of residence. Refer to *Appendix D* for a list of county codes. Code 998 for an out-of-state or foreign country resident. If the medical record has no address, enter the FIPS county code of your institution. For facilities using SCL, the FIPS code will automatically display when the city and zip is entered.

SOCIAL SECURITY NUMBER (Position 180-188)

Every effort should be made to obtain the social security number. This item is used by the TCR to match and consolidate records. If the social security number is not available or unknown, enter all 9's in this position. **Do not put dashes or slashes in this field.**

> ***NOTE:*** *Social Security Numbers are used for Medicare benefits. A suffix "A" on a Medicare number indicates the number is the patient's social security number. Other letter suffixes identify another person's Medicare account. A wife may be registered under her husband's number (i.e. 584-24-4457B). Take caution to enter the* ***patient's*** *number and not the* ***spouse's*** *number.*

★ **CENSUS TRACT** (Position 189-194)

This field will be calculated by the TCR based on information documented in the street and city fields. Census tract is used to calculate incidence rates for geographical areas having population estimates. The US Census Bureau provides population data for census tracts.

DATE OF BIRTH (MMDDYYYY) (Position 195-202)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Date of birth **MUST BE CODED**. This item is used by the TCR to match records. Cases cannot be processed without the date of birth. Enter month, day, and year of the patient's birth. **The year must be coded in full**.

> ***EXAMPLE:*** *January 1, 1954 = 01011954*

Coding Instructions for Confidential Cancer Reporting Form, continued

If month and/or day of birth are not known, code 9's.

EXAMPLE: *1954 = 99991954*

NOTE: *The format for date of birth is numeric (MMDDYYYY), with 99 for unknown day or month (i.e., June 1992, day unknown = "06991992"). Year 1899 = "1899".*

★ **BIRTHPLACE** (Position 203-205)

Record the patient's place of birth if available in the medical record using the SEER Geocodes for Place of Birth from the list below or in *Appendix K*. These codes include states within the United States, as well as foreign countries. Use the most specific code possible.

At the time SEER assigned Geocodes in the 1970's, the United States owned or controlled islands in the Pacific. Many of these islands are now independent. Some are controlled by countries other than the United States. The original codes are used for these islands to preserve historic information. The names have been annotated to show the new political designation. The alphabetic list displays the correct code.

Codes:

071	Arkansas	087	Arizona
073	Louisiana	230	Mexico
075	Oklahoma		
077	Texas	998	Place of Birth outside of the
083	Colorado		United States, geocode unknown
086	New Mexico	999	Place of birth unknown

RACE (Position 206-207)

Enter the two digit code to identify the race of the patient.

The codes are:

01	White	10	Vietnamese	28	Tongan
02	Black	11	Laotian	30	Melanesian, NOS
03	American Indian, Aleutian, Eskimo	12	Hmong	31	Fiji Islander
		13	Kampuchean (Cambodian)	32	New Guinean
04	Chinese	14	Thai	96	Other Asian, including Asian, NOS and Oriental, NOS
05	Japanese	20	Micronesian, NOS		
06	Filipino	21	Chamorran	97	Pacific Islander, NOS
07	Hawaiian	22	Guamanian, NOS	98	Other
08	Korean	25	Polynesian, NOS	99	Unknown
09	Asian Indian, Pakistani, Sri Lankan	26	Tahitian		
		27	Samoan		

Coding Instructions for Confidential Cancer Reporting Form, continued

The **White** category includes Mexican, Puerto Rican, Cuban, Arab, and all other Caucasians.

The **Black** category includes persons of African origin.

If the race is listed as a combination of **White** and any other race, code to the appropriate other race (i.e., a patient's race is listed as **White** but documentation shows the patient is **American Indian**, the appropriate code is 03.). If the race is listed as a combination of non-white races, code to the first non-white race listed (i.e., documentation in the medical record shows the patient has a mixed heritage of **Chinese** and **Korean**, the appropriate code is 04).

The race codes listed correspond to categories used by the US Census Bureau, so that race-specific rates can be calculated. The full coding system should be used to allow accurate national comparisons. The **Race** item is used in conjunction with **Spanish/Hispanic Origin**. **Both items must be coded**.

SPANISH/HISPANIC ORIGIN (Position 208)

This code identifies persons of Spanish or Hispanic origin. The information may be coded from the medical record, or may be based on Spanish names. **Persons of Spanish or Hispanic origin may be of any race**.

All information sources available should be used to determine the correct code, including stated ethnicity in the medical record, stated Hispanic origin on the death certificate, birthplace, and information about life history and language spoken that may be found during the abstracting process, or the Patient's Last Name or Maiden Name being found on a list of Hispanic names.

Codes:

0 Non-Spanish; non-Hispanic
1 Mexican (includes Chicano, NOS)
2 Puerto Rican
3 Cuban
4 South or Central American (except Brazil)
5 Other specified Spanish (includes European)
6 Spanish, NOS; Hispanic, NOS, Latino, NOS (there is evidence other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any of the categories 1-5)
7 Spanish surname only (only evidence of person's Hispanic origin is surname or maiden name)
9 Unknown whether Spanish or not

Use **codes 1-5** if specific ethnicity is known. Use **code 6** when you know the patient is Hispanic but can not classify them in the coding scheme **1-5**. Use **code 7** if patient's race in the medical record is classified as White but the patient has a Hispanic surname (refer to *Appendix J* for Hispanic surnames). Use **code 9** only when no mention of the patient's origin is documented.

Coding Instructions for Confidential Cancer Reporting Form, continued

For example, if a patient's medical record stated the patient was born in Mexico, use the **code 1**. If the patient's medical record stated their race as Hispanic, without mention of whether their origin was Mexico, Puerto Rico, Cuba, etc, use **code 6**. If the patient's medical record states the patient is White/Caucasian, but the patient's last name is Gonzales, use **code 7**.

Persons of Spanish or Hispanic origin may be of any race, but these categories are generally not used for Native Americans, Filipinos, etc who may have Spanish names. If a patient has a Hispanic name but there is reason to believe they are not Hispanic (for example, the patient is Filipino or the patient is a woman known to be non-Hispanic who has an Hispanic married name) the code in this field should be 0, Non-Spanish, non-Hispanic.

Race and Spanish/Hispanic Origin have a significant association with cancer rates and outcomes. Accurate coding is crucial for comparisons between areas with different racial and ethnic distributions.

SEX (Position 209)

Enter the code to identify the gender of the patient. This code must also correspond to the primary site, i.e., prostate cases as male and ovary/breast cases as female, etc.

Codes:

1	Male	4	Transsexual
2	Female	9	Not Stated
3	Other (Hermaphrodite)		

USUAL OCCUPATION AND USUAL INDUSTRY (Position 210-289)

Document the patient's **usual** occupation and industry, the kind of work performed during most of the patient's working life before diagnosis of this tumor, to the extent that it is available in the medical record. If the patient's usual occupation or industry is not available or is unknown, record the patient's current or most recent occupation/industry or any available occupation/industry.

Occupation refers to the patient's **usual** job, such as police officer, bank teller, nurse. Industry refers to the **usual** or primary type of activity carried out at the patient's place of work. Examples include: manufacturing of tires, telephone survey company, and valet service. If the primary type of activity carried on at the location where the patient worked is unknown, record the name of the company along with the city, if available.

★ Do **not** describe the patient's occupation as "**retired**". If there is no documentation in the medical record regarding the patient's usual occupation/industry, record "**not stated or unknown**".

Coding Instructions for Confidential Cancer Reporting Form, continued

If the patient was a housewife/househusband and also worked outside the home during most of his/her adult life, record the usual occupation outside the home; if the patient was a housewife/husband and did NOT work outside the home for most of his/her adult life, record "housewife" or "husband".

If the patient was not a student or housewife and had never worked, record "never worked" as the usual occupation.

Occupation and industry are used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; and identifies occupational groups in which cancer screening or prevention activities may be beneficial.

USUAL OCCUPATION and **USUAL INDUSTRY** (Position 290-295)

This data item will be coded by TCR staff based on documentation provided in the Occupation and Industry field.

SEQUENCE NUMBER (Position 296-297)

This code indicates the chronological sequence of **THIS reportable neoplasm** (the tumor you are preparing the abstract for) in the patient's lifetime. Each **primary tumor** is assigned a **different sequence number**. The codes are:

For **MALIGNANT** carcinomas:

If only ONE primary	If MORE than ONE primary	If sequence is unknown
00 One primary only (First cancer)	01 First of two or more primaries 02 Second of two or more primaries 03 Third of three or more primaries, etc	99 Unspecified

★ For **NONMALIGNANT TUMORS** (benign and borderline) neoplasms:

If only ONE primary	If MORE than ONE primary	Unspecified sequence number
AA One primary only (First benign tumor)	BB Second of two or more benign tumors CC Third of two or more benign tumors DD Fourth of three or more benign tumors, etc	XX Unspecified

Coding Instructions for Confidential Cancer Reporting Form, continued

NOTE: *The **Sequence Number** identifies the total number of tumors this patient has been diagnosed with, regardless of where the patient received treatment. This code differs from **Tumor Record Number** defined on page 10, which identifies only the number of tumors seen at the reporting institution.*

EXAMPLES:

1. *For a person diagnosed with one primary only, e.g. lung cancer, the sequence number would be "**00**".*
2. *For a person diagnosed with breast cancer in April 1995 and a diagnosis of metastasis to the lungs in November 1995, the breast cancer would be given a sequence number of "**00**". Since the lung is a metastatic site and not a second primary it would not be abstracted or given a sequence number.*
3. *For a person diagnosed with thyroid cancer in 1978 and a gallbladder cancer in 1995, the thyroid cancer would be given a sequence number of "**01**" and the gallbladder cancer would be given a sequence number of "**02**".*
4. *For a person diagnosed with papillary serous adenocarcinoma of the ovaries in 1993 and who in 1995 developed a benign meningioma in the temporal area of the brain, the ovaries would be given a sequence number of "**00**" and the brain would be given a sequence number of "**AA**".*
5. *For a person diagnosed with adenocarcinoma of the stomach in 1977, squamous cell carcinoma of the left forearm (a non-reportable neoplasm) in 1994, and now presents with a non-Hodgkin's lymphoma, the stomach would be given a sequence number of "**01**", the left forearm* would be given a sequence number of "**02**" and the lymphoma would be given a sequence number of "**03**".*

***NOTE:** Even though squamous cell carcinoma of the skin is not reportable to the TCR, it should be considered when assigning the appropriate sequence number. However, regardless of the number of squamous/basal cell carcinomas of the skin a patient has, it should only be counted once when calculating the sequence number.*

If two or more independent primaries are diagnosed at the same time, the lowest sequence number will be assigned to the diagnosis with the worst prognosis. Extent of disease and morphology should be considered. If no difference in prognosis is evident, the decision must be arbitrary.

***EXAMPLE:** For a patient who is diagnosed with small cell carcinoma of the lung and squamous cell carcinoma of the cervix at the same time, the sequence number would be documented as follows:*

Lung: 01
Cervix: 02

Coding Instructions for Confidential Cancer Reporting Form, continued

OTHER PRIMARY TUMORS (SITE, MORPHOLOGY, AND DATE) (Position 298-397)

Complete **only** if sequence number is anything ***other than*** "**00**" (one primary only). Record the site, morphology, and date of **any other** primary tumors diagnosed in the past at this institution or elsewhere. Do **not** include metastatic lesions or the primary tumor currently being reported in this field.

> ***EXAMPLE:*** *The patient had a history of duct cell carcinoma of the left breast in 1991 and is admitted now for adenocarcinoma of the lung; complete a report on the lung tumor, and record "duct cell carcinoma, left breast, 1991" in this area.*

OTHER PERTINENT INFORMATION (Position 398-497)

Document other pertinent information for which adequate or appropriate space has not been provided on the reporting form. Such information may include additional staging information, treatment documentation, history of the disease or comments regarding lack of information in the medical record.

DATE OF (INITIAL) DIAGNOSIS (MMDDYYYY) (Position 498-505)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Enter the date (month, day, century and year) of initial diagnosis of this cancer by a recognized medical practitioner by any method, **regardless** of whether the diagnosis was made at the ***reporting institution or elsewhere***. This may be a clinical diagnosis without histological confirmation. If confirmed later histologically, the diagnosis date remains the date of the first clinical diagnosis and not the date of confirmation.

★ If the date of diagnosis is from a pathology report, the date of diagnosis will be the date the specimen was taken, not necessarily the same date the pathology report was read. If upon medical and/or pathological review the patient is deemed to have had cancer at an earlier date, record that date. For "Autopsy Only" cases , use the date of death for the date of diagnosis.

In the absence of an exact date of initial diagnosis, **make the best approximation**. If the month and day are not known, code 9's, and enter year of diagnosis. For vague dates use the following: "Spring" enter as April; "Summer" enter as July; "Fall" enter as October; and "Winter" enter as January. If there is no basis for an approximation for an earlier date of diagnosis, code all 9's.

EXAMPLES:

1. *For a patient admitted to your facility on 12/15/95 for hip replacement who also has prostate carcinoma diagnosed approximately 2 months ago, the date of diagnosis would be "10991995".*
2. *For a patient admitted to your facility on 9/10/95 to rule out a myocardial infarction and has bone and brain metastasis from a malignant melanoma diagnosed in the fall 4 years ago, the date of diagnosis would be "10991991".*

MORPHOLOGY: TYPE AND BEHAVIOR (Position 506-510)

★ The ICD-O-2 is to be used for coding and reporting the morphology and behavior of tumors. If your facility has staff qualified to code this position, **adequate text documentation must be provided to support the ICD-O code**.

NOTE: *Autocoding of the ICD-O codes is not considered adequate documentation.*

If your facility does not have staff experienced in ICD-O coding (for example, non-cancer registry hospitals), this position should be left blank. **Adequate documentation of tumor cell type must be provided** in the **FINAL DIAGNOSIS** section of the reporting form to enable TCR staff to code.

Guidelines for Reporting and Coding Morphology

Use all pathology reports available to report the cell type of the tumor. Generally, the pathology report from a resection or an excision is most representative of the tumor's histology; however, the pathology report from an incisional biopsy is adequate if the tumor is nonresectable.

Coding Instructions for Confidential Cancer Reporting Form, continued

The microscopic description as well as the final pathologic diagnosis should be studied for specific information relating to the cell type of the tumor.

> ***EXAMPLE:*** *The microscopic description may say the tumor is "mucin-producing", "papillary" or "keratinizing", but the final pathologic diagnosis may read only "carcinoma" or "adenocarcinoma". Modify the final pathologic diagnosis to include specific terms such as "mucin-producing".*

If there are two morphologies in the same lesion, and the 5th digit is the same, code to the highest morphology code if no combined morphology code exists.

> ***EXAMPLES:***
> *A. Biopsy: Squamous cell carcinoma of cervix (80703).*
> *Surgery: Squamous cell carcinoma, keratinizing type, of cervix (80713)*
> *Code to the highest morphology (80713).*
> *B. Path report: Mixed adenocarcinoma and squamous cell carcinoma of cervix.*
> *Code to the combination code for adenosquamous carcinoma (85603).*

If the fifth digit is **not** the same, select the morphology code with the higher behavior code (the invasive tumor).

> ***EXAMPLE:***
> *Report 1: Papillary transitional cell carcinoma in situ (81302).*
> *Report 2: Transitional carcinoma (81203).*
> *Code to invasive transitional carcinoma (81203).*

> ***EXCEPTION:*** *If the histology of the invasive component is an "NOS" term (e.g., carcinoma, adenocarcinoma, melanoma), then use the specific term associated with the in situ component and an invasive behavior code.*

> ***EXAMPLE:***
> *Report 1: Squamous cell carcinoma in situ (80702).*
> *Report 2: Carcinoma, NOS (80103).*
> *Code to Squamous cell carcinoma (80703).*

Use caution when describing the pathological diagnosis. What appears to be minor differences in histological terms can have major implications.

PRIMARY SITE (Position 511-514)

★ The ICD-O-2 is used for coding and reporting the primary site of all tumors. If your facility has staff qualified to code this position, **adequate text documentation must be provided to support the ICD-O code.**

Coding Instructions for Confidential Cancer Reporting Form, continued.

NOTE: *Autocoding of the ICD-O codes is not considered adequate documentation.*

If your facility does not have staff experienced in ICD-O coding (for example, non-cancer registry hospitals), this position should be left blank. **Adequate documentation of tumor cell type must be provided** in the **FINAL DIAGNOSIS** section of the reporting form to enable TCR staff to code.

Record information which most accurately identifies the anatomical site of the primary neoplasm, the organ or tissue of **origin**. The exact location of the primary tumor is not always stated in the pathology report or discharge diagnosis. It is necessary to review the entire medical record in order to obtain the most precise description of the primary site.

EXAMPLE: *The path report states "Right breast resection specimen: Infiltrating ductal carcinoma." The discharge diagnosis states "Infiltrating ductal carcinoma, right breast." However, the Physical report states "Examination of the right breast reveals a mass in the upper outer quadrant." Record the more detailed description from the Physical: Upper outer quadrant right breast.*

Where the information in the medical record regarding morphology, behavior, tumor size or lymph nodes is conflicting, statements in the pathology report generally take precedence over other statements.

EXAMPLE*: The pathology report states "5.4 x 3.2 cm tumor, infiltrating adenocarcinoma in a sessile polyp of the transverse colon, no lymph nodes identified in specimen". The discharge summary states infiltrating adenocarcinoma of the transverse colon. Record the information from the pathology report: 5.4 x 3.2 cm tumor, infiltrating adenocarcinoma in a sessile polyp of the transverse colon, no lymph nodes identified.*

Guidelines for Reporting and Coding Primary Site

In the Introduction section of the ICD-O, the topic of "Site-Specific Morphology Terms" is discussed. If the patient's medical record has a morphologic term with a C number listed in ICD-O, use this C number **if** no definite site is given or **if** only a metastatic site is given. For example, if the diagnosis is Hepatoma (81703) with no other statement about topography, code to primary site C220 (liver) as this morphology is usually indicative of a primary malignancy in the liver.

In general, when a primary site is preceded by "*carcinoma of* ..." or "*malignancy of* ...", code to that primary site except for the following, which are generally metastatic sites:

- Bone
- Brain, spinal cord, meninges
- Liver
- Lymph nodes (except lymphoma)
- Pleura (except mesothelioma)
- Peritoneum, retroperitoneum, pericardium (except mesothelioma)

Coding Instructions for Confidential Cancer Reporting Form, continued

If the final diagnosis reflects carcinoma of one of the above sites, carefully review documentation included in the medical record to identify the actual primary site. If there is no further documentation, please state so in the final diagnosis section.

Each four character site of colon (C180-C189), rectum, anus and anal canal (C199, C209, C210-C218), bone (C400-C419), connective tissue (C490-C499), peripheral nerves (C470-C479), and melanoma of the skin (C440-C449), is considered to be a separate primary site. All other four character site codes are considered to be subsites of a major three character site. For example, upper-inner quadrant of the breast (C502) is considered to be a subsite of the breast, C50_. The section *Criteria for Determining Multiple Primaries (Appendix G)* can be used to help determine the number of primary cancers to be reported.

Additional guidelines for primary site include:

* Lymphoma, primary unknown = C779. Approximately 25% of lymphomas originate in extranodal sites such as the stomach, intestine, or breast. The topography code for a lymphoma primary originating in an organ or extranodal site should be the code for that organ or extranodal site. For example, malignant lymphoma of stomach should be coded C16_. Be sure to code to the primary site; it may not, in some cases, be the same as the site of biopsy. If a specific lymph node is the primary site, code accordingly.
* Leukemia = C421. Since blood cells originate in bone marrow, all leukemias are coded to bone marrow (C421), except myeloid sarcoma and leukemic reticuloendotheliosis.
* Melanoma, primary unknown = C449.
* Kaposi's sarcoma is coded to the site in which it originates. If Kaposi's sarcoma originates in skin and another site simultaneously, code to skin (C44_). If no primary site is stated, code to skin (C449).
* Mycosis fungoides = C44_.

GRADE OF TUMOR (Position 515)

The grade or differentiation of the tumor describes the resemblance of the tumor cells to their normal tissue counterparts. The more undifferentiated the tumor, the greater the incidence of metastasis and the more rapid the clinical course. The terms "grade" and "differentiation" are used synonymously. Grade is best determined from the specimen obtained at resection of the primary site. If this is unavailable, the grade from a biopsy of the primary site, a biopsy of a metastatic site, or cytology should be used in that order.

When there is no tissue diagnosis, it may still be possible to establish the grade of a tumor through Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET). In particular, it is now possible to grade brain tumors by this method. Thus, if there is no tissue diagnosis, but there is a grade/differentiation available from an MRI or PET report, code the grade based on those reports. If there is a tissue diagnosis, code for grade should be based on the pathology report only.

Text documentation should be provided in the final diagnosis section of the reporting form to support the code assigned for the grade/differentiation.

Coding Instructions for Confidential Cancer Reporting Form, continued

★ If grade is not documented in the medical record, assign the grade "9". There are certain histologies in the past which were automatically assigned a grade if no grade was documented in the medical record, i.e., small cell carcinoma, large cell carcinoma of the lung, some astrocytomas and glioblastomas, rhabdomyosarcomas of the soft tissue, Ewing's sarcoma of bone and soft tissue, and undifferentiated carcinomas to name a few.

Occasionally a grade is written as "2/3", meaning this grade is 2 of a 3 grade system, and should be coded "3" for Grade III. Other times a grade will be written "3-4", meaning this is a grade 3 to 4, and should be coded to the higher grade "4" undifferentiated.

The codes for grade/differentiation are:

1 Grade I Well differentiated, Differentiated NOS
2 Grade II Moderately differentiated, Moderately well differentiated, Intermediate differentiation, Partially well differentiated, Partially differentiated, Low grade NOS
3 Grade III Poorly differentiated, Moderately undifferentiated, Relatively undifferentiated, Slightly undifferentiated, Medium grade NOS
4 Grade IV Undifferentiated, Anaplastic, Dedifferentiated, High grade NOS
5* T-cell, T-precursor
6* B-cell, Pre-B, B-precursor
7* Null cell, Non T-non B (**for leukemias only**)
★ 8* Natural Killer (NK) Cell
9 Grade or differentiation not determined, not stated, or not applicable

***Codes for T-cell and B-cell designation for lymphomas and leukemias**

★ For lymphomas, do not code the descriptions "high grade," "low grade," or "intermediate grade" in this field. These terms refer to categories in the Working Formulation of lymphoma diagnoses and not to histologic grade. For lymphomas and leukemias, information on T-cell, B-cell, or null cell has precedence over information on grading or differentiation. However, if the grade is specifically stated i.e. moderately differentiated, poorly differentiated, well differentiated, and the cell is not indicated you would code the grade in the appropriate box and the morphology as well.

FIGO (International Federation of Obstetrics and Gynecology) grades are not coded as Grade of Tumor on this form.

Black's nuclear grade reverses the numerical order of conventional grading systems. Codes for Blacks Nuclear Grade are:

Code	Blacks Nuclear Grade	Differentiation
3	Grade 0 and I	Poorly
2	Grade II and III	Moderately
1	Grade IV	Well

Coding Grade for Prostate Cases

Prostate cancers may be graded using Gleason's score or pattern. Gleason's grading for prostate primaries is based on five histologic patterns. The primary pattern is usually indicated by the first number of the Gleason's grade and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10. If only one number and it is less than or equal to 5, assume a pattern. If only one number and it is greater than 5, assume a score. If two numbers, assume two patterns and sum them to obtain the score.

1. If Gleason's score (2-10) is given, code as follows:

Gleason's score	**Grading**	**Code**
2, 3, 4	I Well Differentiated	1
5, 6, 7	II Moderately Differentiated	2
8, 9, 10	III Poorly Differentiated	3

2. If Gleason's pattern (1-5) is given, code as follows:

Gleason's pattern	**Grading**	**Code**
1, 2	I Well Differentiated	1
3	II Moderately Differentiated	2
4, 5	III Poorly Differentiated	3

If not identified as Gleason's, assume a non-Gleason grade system and code appropriately. If both a non-Gleason grade and a Gleason grade are given, **code the non-Gleason grade**.

New Grading Scheme for Breast Cancer

A new grading scheme, similar to the Gleason's scheme for prostate cancer, has been approved by national standard-setting organizations for breast cancer cases diagnosed beginning January 1, 1996. The scheme which is based on a numerical scoring system, can be used for any site, but is usually applied to breast cases. Three separate histological factors (glandular differentiation, nuclear pleomorphism, and mitotic rate) are evaluated and a point value assigned as follows: slight (1 point); moderate (2 points); and marked (3 points). The points are added to obtain a total score, which reflects the grade as follows:

Points	**Grade**	**Code**
3-5	grade I, well differentiated, low grade	1
6-7	grade II, moderately differentiated, intermediate grade	2
8-9	grade III, poorly differentiated, high grade	3

★ **Modified Bloom-Richardson scheme for breast cases:**

Effective with breast cancer cases diagnosed beginning January 1996, when the terms "low," "intermediate," and "high" grade are used the grading system is specified as (Scarff) Bloom-Richardson (BR). Code the grade as 1, 2, and 3 respectively. This is an exception to the usual rule for all other grading systems that "low," "intermediate," and "high" are coded 2, 3, and 4 respectively. In the (Scarff)

BR system, if grades 1, 2, and 3 are specified, these should be coded 1, 2, and 3 respectively.

Coding Instructions for Confidential Cancer Reporting Form, continued

SEER suggests these coding guidelines; use grade or differentiation information from the breast histology in the following order:

1. Terminology (differentiation: well, moderately, poorly, moderately-well, etc.; i, ii, iii, etc.)
2. BR scores (range 3-9, converted to grade)
3. BR grade (low, intermediate, high)
4. Nuclear grade only

BR combined scores	Differentiation/BR Grade	Appropriate Grade Code
3, 4, 5	well differentiated (BR low grade)	1
6, 7	Moderately differentiated (BR intermediate grade)	2
8, 9	Poorly differentiated (BR high grade)	3

NOTE: *BR score may also be called Elston-Ellis modification of BR score.*

LATERALITY (Position 516)

Enter the code to identify the laterality of a paired site as follows:

0 Not a paired site
1 Right: origin of primary
2 Left: origin of primary
3 Only one side involved, right or left origin unspecified
4 Bilateral involvement, lateral origin unknown: stated to be single primary; including both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms' tumors
9 Paired site, but no information concerning laterality; midline tumor

Bilateral sites requiring a code of "1" - "9" are listed in *Appendix F.*

Laterality should **not** be coded for unknown primaries or non-paired sites (even if a laterality is stated); use code "0".

EXAMPLE: *Patient admitted for surgical resection of tumor in right colon. Code "0" for "Not a paired site" must be assigned (not code "1"). Right colon refers to the ascending colon which is not a paired site; therefore, a code of "0" should be used.*

FINAL DIAGNOSIS - Morphology and Primary Site Documentation: (Position 517-596)

★ Following the guidelines listed previously, enter the patient's morphology (histological type and behavior), grade, primary site and laterality. Do not use the generic ICD-9-CM code statement found on the face sheet or attestation sheet. Text information to support cancer diagnosis, stage and treatment codes should be provided by facilities without a *documented data quality program* such as one approved by the American College of Surgeons.

EXAMPLES:

Morphology:	*Moderately Well Differentiated (MWD or mod well diff) Mucin-Producing Adenocarcinoma (adenoca).*
Primary Site:	*Ascending (asc) Colon*
Morphology:	*Grade 3, Infiltrating Ductal and Lobular Carcinoma*
Primary Site:	*Upper Outer Quadrant (UOQ) Right (Rt) Breast*
Morphology:	*Anaplastic Astrocytoma*
Primary Site:	*Temporoparietal lobe*
Morphology:	*Intermediate Grade (grd) Large (lg) Cell Carcinoma*
Primary Site:	*Left Lower Lobe (LLL) of the Lung*

DIAGNOSTIC CONFIRMATION (Position 597)

This position indicates the most accurate method by which the reportable tumor was diagnosed. The code for this position may change if, **at ANY time during the patient's medical history,** there was microscopic or other confirmation of the malignancy.

All diagnostic reports in the patient's medical record should be reviewed to determine the most definitive method used to confirm the diagnosis of cancer. This review should also cover the patient's entire medical history in regard to the primary tumor.

If the patient was diagnosed prior to admission to your institution, review the history section to identify information regarding previous diagnostic tests and treatments. If the patient was diagnosed elsewhere, copies of the pathology or radiology reports may be included in the record. If the patient had a biopsy or resection of the tumor, it can be assumed that the diagnostic confirmation was histologic. Use code 9 (unknown), **only** if no evidence of a definitive diagnosis can be found.

EXAMPLES:

1. If a mammography showed a lesion suspicious for cancer, two weeks later a biopsy confirms infiltrating ductal carcinoma, the correct diagnostic confirmation code would be "1" for histologic confirmation.

2. A patient was initially diagnosed with a glioblastoma by MRI and a year later a surgical biopsy is obtained. The code for diagnostic confirmation code should be (or can be changed to) a "1".

Coding Instructions for Confidential Cancer Reporting Form, continued

3. A thoracentesis is performed for a patient who is found to have a large pleural effusion. Cytology reveals malignant cells consistent with adenocarcinoma. The diagnostic confirmation code is a "2" for cytologic confirmation.

4. CT of the abdomen reveals metastatic deposits in the liver and a large lesion in the ascending colon. Biopsy and later resection of the colon lesion revealed mucin-producing adenocarcinoma. The diagnostic confirmation code is "1" for histologic confirmation.

The codes in order of their conclusiveness are:

Microscopically Confirmed

1 Histology -- Microscopic diagnoses based upon tissue specimens from biopsy, frozen section, surgery, autopsy, or D and C. This method provides the most accurate evidence of the presence of cancer. **Positive hematologic findings relative to leukemia are also included. Bone marrow specimens (including aspiration biopsies) are coded as '1'.**

2 Cytology -- Cytologic diagnoses with no positive histology. Examples are pap smears, bronchial brushings, and peritoneal fluid. Cervical and vaginal smears are common examples. Also included are diagnoses based upon paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.

4 Microscopic Confirmation, NOS -- Diagnoses stated to be microscopically confirmed but method not specified.

Not Microscopically Confirmed

5 Laboratory test/marker study -- Clinical diagnosis of cancer based on certain laboratory tests or marker studies. Examples are the presence of alpha-feto protein for liver cancer and an abnormal electrophoretic spike for multiple myeloma.

6 Direct Visualization -- Visualization without microscopic confirmation. Examples are diagnoses from exploratory laparotomy or endoscopy.

7 Radiography/Imaging -- Radiology and other imaging techniques without microscopic confirmation. Examples are ultrasound, CAT scans, and magnetic resonance imaging (MRI).

8 Other -- Cases diagnosed by clinical methods not mentioned above and for which there were no positive microscopic findings.

Confirmation Unknown

9 Unknown -- Cases for which it is unknown whether or not microscopically confirmed.

Coding Instructions for Confidential Cancer Reporting Form, continued

★ **TUMOR SIZE** (Position 598-600)

Size of tumor is the largest dimension, or the diameter of the **primary tumor**, and is always recorded in millimeters.

To convert centimeters to millimeters, move the decimal point one digit to the right **OR** multiply the centimeters by 10.

EXAMPLE: *3.2cm becomes 032 mm.*

Round off decimals to the nearest tenth.

EXAMPLE: *3.21 becomes 3.2cm and is recorded as **032**.*
*2.16 cm becomes 2.2 cm and is recorded as **022**.*

Rules for coding **TUMOR SIZE**:

* When recording tumor size from the pathology report, be sure to differentiate between the tumor size and the specimen size.

NOTE: *Do not calculate a size by adding the sizes of pieces or chips of tissue together; they might not be from the same location, or might represent only a small portion of a larger tumor.*

EXAMPLE: *The pathology report for a colon resection describes a specimen that measures 14.5 x 10.1 cm. Dissection reveals a 3.5 x 2.6 cm lesion. Record the **tumor size** for the lesion as **035**.*

* Record the largest size when the tumor has multiple measurements.

EXAMPLE: *The pathology report describes the tumor size as 3 x 4.4 x 2.5 cm. Record the **tumor size** as 044 mm.*

* Record the size of the **invasive** component only when a tumor has both in-situ and invasive components.

EXAMPLE: The pathology report describes a breast mass as a 2 x 1.5 cm intraductal carcinoma and a 1 cm of infiltrating ductal carcinoma. Record the **tumor size** as **010 mm**.

Coding Pathological vs Clinical size:

* Record the size documented on the pathology report when:
  - the pathologist identifies the size of a completely excised primary tumor, and
  - the surgical margins are grossly free of disease (there may be microscopic involvement).

Coding Instructions for Confidential Cancer Reporting Form, continued

EXAMPLES: *The pathology report describes a 5.3 x 4.2 cm colon lesion consistent with adenocarcinoma, tumor extends microscopically to involve inked margins. The op report states all tumor grossly removed. Record the* ***tumor size*** *as* ***053****.*

The pathology report describes a 3.5 x 2.2 cm mass in the stomach with tumor extending grossly to involve margins. The op report states mass was incompletely resected. With no other indication of tumor size, record the ***tumor size*** *as* ***999****.*

* Record the clinical size of the tumor when:
- the tumor was not surgically excised;
- the primary tumor was excised but the margins were grossly involved;
- the primary tumor was excised but the pathology report does not specify tumor size; or
- the patient was treated with radiation therapy, chemotherapy, hormone therapy, or immunotherapy before the primary was surgically excised.

EXAMPLES: *A patient was admitted for evaluation of chronic cough, hemoptysis, and a suspicious looking mass on CXR. CT Chest revealed a 3 cm mass in the RUL of the lung. Biopsy consistent with adenocarcinoma. Patient and family refused further work-up or treatment. Record* ***tumor size*** *as* ***030****.*

A colonoscopy revealed a large, suspicious looking lesion in the rectosigmoid area, biopsy confirms an adenocarcinoma with positive margins. The patient is referred to another institution for surgical resection. With no further documentation of the size of the tumor, record the ***tumor size*** *as* ***999****.*

Patient presents now for surgical resection following chemotherapy to reduce the size of the tumor. Prior to chemotherapy, the patient was diagnosed with a 10 cm lf breast mass. Record the ***tumor size*** *as* ***100****.*

★ **REGIONAL NODES POSITIVE** (Position 601-602)

Regional Nodes Positive describes the number of surgically removed regional nodes examined by the pathologist and reported as containing tumor. Code only regional lymph nodes.

Codes:

00	All nodes examined negative
01	One positive lymph node
02	Two positive lymph nodes
03	Three positive lymph nodes
..	..
10	Ten positive lymph nodes
..	..
96	96 or more positive lymph nodes
97	Positive lymph nodes but number not specified
98	No nodes examined
99	Unknown if nodes are positive or negative, not applicable

Coding Instructions for Confidential Cancer Reporting Form, continued

Use code 98 when no nodes are removed or examined.

Use code 99 for sites for which information about the field is unknown or not applicable.

EXAMPLES: *Brain*
Leukemia
Lymphoma (nodal)
Multiple Myeloma
Reticuloendotheliosis
Letterer-Siwe's disease
Unknown Primaries
Patient was treated with radiation, chemotherapy, hormone therapy, or immunotherapy before surgery

NOTE: *The number of positive lymph nodes cannot exceed the number of regional lymph nodes examined.*

★ **REGIONAL NODES EXAMINED** (Position 603-604)

Regional Nodes Examined describes the total number of surgically removed regional nodes that a pathologist examined. Only regional nodes should be counted. Removal of the primary tumor and a lymph node dissection may be done in one procedure, or the nodes may be removed in a separate procedure.

Record in Regional Nodes Examined if the lymph node dissection is documented in the treatment plan and is done as part of the first course of therapy.

Do NOT record in Regional Nodes Examined if the lymph node dissection is performed after the first course of therapy (nodes removed to establish recurrence or progression of disease).

Codes:

00 No nodes examined, no nodes surgically removed
01 One node examined
02 Two nodes examined
03 Three nodes examined
.. ..
10 Ten nodes examined
.. ..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) were performed
96 Regional lymph node sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown/not stated if nodes were examined; not applicable; or death certificate only

Use code 99 for sites for which information about the field is unknown or not applicable.

EXAMPLES: *Brain* *Reticuloendotheliosis*
Leukemia *Letterer-Siwe's disease*
Lymphoma (nodal) *Unknown Primaries*
Multiple Myeloma
Patient was treated with radiation, chemotherapy, hormone therapy, or immunotherapy before surgery

EXAMPLES *(coding regional nodes positive and regional nodes examined):*

1. *The pathology report states: Nine out of twenty-two hilar nodes are positive for metastatic adenocarcinoma.*

   Record: *Regional nodes positive: 09*
   Regional nodes examined: 22

2. *Physical exam revealed a large lesion in the RUOQ of the breast. Incisional biopsy confirmed infiltrating ductal carcinoma. Patient refused work-up or treatment.*

   Record: *Regional nodes positive: 98*
   Regional nodes examined: 00

3. *The pathology report states: Moderately differentiated mucinous adenocarcinoma of the colon. Two out of 10 pericolic lymph nodes positive for metastasis.*

   Record: Regional nodes positive: 02
   Regional nodes examined: 10

4. The pathology report states: All regional nodes examined negative.

   Record: Regional nodes positive: 00
   Regional nodes examined: 98

5. During work-up of a prostate carcinoma, CT of the pelvis revealed probable metastatic iliac lymph nodes.

   Record: Regional nodes positive: 98
   Regional nodes examined: 00

6. Patient was diagnosed with multiple myeloma.

   Record: Regional nodes positive: 99
   Regional nodes examined: 99

GENERAL SUMMARY STAGE (Position 605)

The Summary Staging Guide, 1977 that is published as a Self-Instructional Manual for Tumor Registrars, is a **recommended reference** for the documentation of GENERAL SUMMARY STAGE on the TCR Reporting Form. This resource (NIH Publication Number 92-2313) can be obtained from SEER. The mailing address is:

National Cancer Institute
Building 31, Room 10A16
Bethesda, MD 20892-3100
301/496-8510

The General Summary Stage is a summary of the extent of disease categorized as in-situ, localized, regional, and distant.

★ **In-situ** (Figure 1) describes a neoplasm that is "noninvasive" and confined to a small circumscribed area within the tissue of origin. An in-situ lesion can only be diagnosed by microscopic examination.

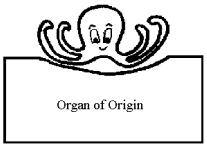


Figure 1

★ **Localized** (Figure 2) indicates a neoplasm that has not spread beyond the organ of origin or basement membrane. For a lesion to be classified as “localized”, there must be no extension beyond the outer limits of the primary organ and no evidence of metastasis elsewhere in the body. The tumor may be widely invasive, or even show metastasis within the organ of origin (primary site) and still be considered “localized”.

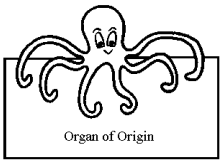


Figure 2

★ **Regional** (Figure 3) identifies a tumor that has spread to adjacent organs or tissues or to lymph nodes surrounding the primary organ. Lesions that have reached this stage are probably the most difficult to categorize. Two factors are important in assigning cases to this stage: first, it must be established that the cancer is more than localized; and second, remote spread must be reasonably ruled out on the basis of all evidence available in the medical record.

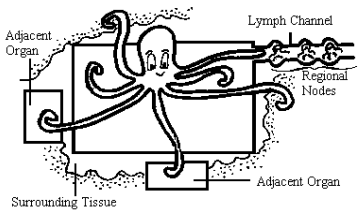


Figure 3

Coding Instructions for Confidential Cancer Reporting From, continued

★ **Distant** refers to a neoplasm that has extended to remote areas from the primary tumor by metastasis either through the blood system (Figure 4), distant lymph nodes (Figure 5) or by implantation metastasis (Figure 6).

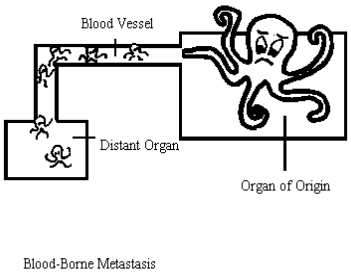


Figure 4

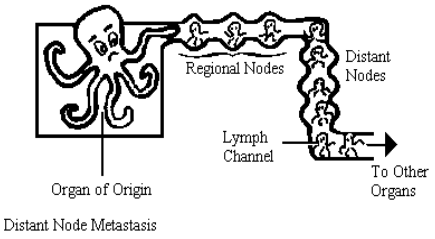
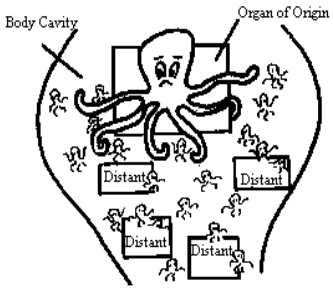


Figure 5

Figure 6



Unknown is used when there is insufficient information to determine stage or extent of disease.

In order for the TCR staff to accurately code stage of disease, all necessary information from the medical record must be documented. Extent of disease is based on a combined clinical and surgical assessment and should be limited to all information available within **two months** after diagnosis for all sites except for prostate primaries. General summary stage for prostate primaries is limited to all information available within **four months** of diagnosis. Certain components of the medical record are vital to correctly assess the spread of the tumor. Both positive and negative findings that are pertinent to describing the spread of the tumor from the primary site should be recorded on the reporting form under **STAGING INFORMATION**.

The following list, although not inclusive, contains pertinent pieces of the medical record which are helpful when documenting the staging information:

Pathology reports -- contain details on morphology, topography, stage of disease, etc;
Operative reports -- may contain information on stage of disease, and origin of tumor;
Scans, x-rays, lab tests, & scopes -- may contain information on staging;
History and Physical (H&P) -- may contain additional information on race, other tumors, staging information, and primary site; and
Discharge summary -- may contain supplemental information on diagnosis treatment, topography and staging information.

If you encounter records in which you cannot adequately determine the appropriate information to document, **attach copies of the necessary reports to the Reporting Form** so TCR staff can determine the correct code. You may also call your regional program for technical assistance.

If your facility has staff experienced in staging, this position may be completed using the codes listed below. Otherwise, TCR staff will complete this field based on staging documentation provided.

Codes:

0 In Situ
1 Localized
2 Regional by direct extension
3 Regional to lymph nodes
4 Regional (direct extension AND lymph nodes)
5 Regional, NOS
7 Distant metastasis/systemic disease i.e.,leukemia, multiple myeloma
9 Unstaged, unknown, unspecified

★ ***NOTE:*** *Autocoding of stage is not considered adequate documentation.*

STAGING INFORMATION (Position 606-2355)

Stage documentation is REQUIRED, even if your facility codes this position. Documentation must be provided from state reporting facilities without an approved cancer program. Facilities approved by the American College of Surgeons without a *documented data quality program* should provide text information.

Refer to guidelines under General Summary Stage. Information such as lymph node involvement, invasion to tissues or organs adjacent to primary site, and spread to distant sites should be included. Please document **both the date and source of** staging information. This will help TCR staff to determine if this information can be used to code stage. If little or no information on extent of disease at diagnosis is found in the medical record, enter *"unknown staging information"* or *"no other staging information available"* in this area. When documenting staging information, be concise, complete, and use abbreviations whenever possible.

★ Listed below are terms that indicate **tumor involvement**:

adherent
apparent
compatible with
consistent with
encroaching upon
extension to
extension into
extension onto
extension out onto
fixation, fixed
induration
into
invasion to
invasion into
invasion onto
invasion out onto
most likely
onto
out onto
presumed
probable
suspect
suspicious
to
typical of/for

Coding Instructions for Cancer Reporting Form, continued

★ Terms that **do not** constitute involvement:

abuts	*rule out*
approaching	*suggests*
equivocal	*very close to*
possible	*worrisome*
questionable	

★ The terms *"entrapped"* and *"encased"* should not be interpreted as involvement in the absence of other evidence to indicate there was involvement.

★ **Terms indicating in-situ:**

Adenocarcinoma in an adenomatous polyp with no invasion of stalk
Bowen's Disease
Clark's Level I for melanoma (limited to epithelium)
Comedocarcinoma, noninfiltrating
Confined to epithelium
Hutchinson's melanotic freckle, nos
Intracystic, non-infiltrating
Intraductal
Intraepidermal
Intraepithelial
Intrasquamous
Involvement up to but not into the basement membrane
Lentigo maligna
Lobular neoplasia
Lobular, noninfiltrating
No stromal invasion
Non-infiltrating
Non-invasive
Papillary, noninfiltrating or intraductal
Precancerous melanosis
Preinvasive
Queyrat's erythroplasia
Stage 0

★ **The following terms or conditions are indicative of *distant* or *discontinuous* metastasis:**

carcinomatosis	*malignant pleural effusion*
implantation	*seeding*
implants	*studding*
malignant ascities	

Coding Instructions for Confidential Cancer Reporting Form, continued

Document staging information, using standard abbreviations whenever possible, as follows:

Both negative and positive findings from radiology reports, i.e. CT BRAIN-NEMD; CXR-neg; MRI ABD-no evid of mets; CT ABD-liver mets; BONE SCAN-incr uptake c/w mets.
Lymph node (ln) involvement, i.e. reg ln invlvd; 12 ax nodes +; no mets to examined reg ln.
Invasion to tissues/organs adjacent to primary site, i.e. breast tmr invading chest wall; malignant melanoma deeply invasive to subq tissues.
Any distant metastasis, i.e. liver mets; brain mets; bone mets.
Significant lab values, i.e., elevated calcium, alkaline phosphatase, LDH, any tumor markers (such as ER/PR, CEA, CA 19-9, CA 125).

★ **Lymph Nodes:** For solid tumors, the terms "fixed" or "matted" and "mass in the mediastinum, retroperitoneum, and/or mesentery" (with no specific information as to tissue involved) are considered involvement of lymph nodes. Any other terms, such as "palpable", "enlarged", "visibly swelling", "shotty", or "lymphadenopathy" should be ignored; look for a statement of involvement, either clinical or pathological.

A metastatic nodule in connective tissue of a lymph drainage area is considered to be evidence of lymph node metastasis.

If a specific lymph node chain is not listed among the regional lymph nodes (in the SEER Summary Staging Guide), it should be considered a distant metastasis if it is involved.

★ **Venous Invasion:** *Venous invasion* is an assessment of blood vessels **within** the primary organ. This does not constitute regional or distant spread of malignancy.

★ **Lymphatic Invasion:** *Lymphatic invasion* is a microscopic assessment of involvement of the lymphatic channels **within** the primary organ and at the margins of resection. This is an assessment of the potential, from the primary tumor, to metastasize to lymph nodes, even though the tumor has extended no further than the lymph channels and is still confined to the primary site.

★ **Residual Tumor:** *Residual tumor* refers to the status of the margins after a surgical procedure of the primary site. It is important to document this information if it is available in the pathology and/or operative report.

Microscopic residual tumor is that which is identified by the pathologist through the microscope but which is not apparent visually. An example would be a positive margin of resection when the surgeon stated that the tumor was completely removed.

Macroscopic residual tumor is identified during the procedure by the surgeon and is tumor that is grossly visualized. An example of this would be tumor adhering to another structure that the surgeon could not remove.

Coding Instructions for Confidential Cancer Reporting Form, continued

★ **Lymphomas:** For lymphomas, **any** mention of lymph nodes is indicative of involvement.

In staging lymphomas, bilateral node involvement should be considered 2 chains for the purpose of assigning a stage. For example, bilateral inguinal nodes, bilateral iliac nodes, etc., would be considered 2 chains.

When there is doubt about assigning the appropriate stage assign the lesser stage. Do not over stage.

The following are scenarios with examples of how to document staging information. Sites included are bladder, breast, colon, lung, and prostate.

★ **Bladder** (Figure 7 and Figure 8)

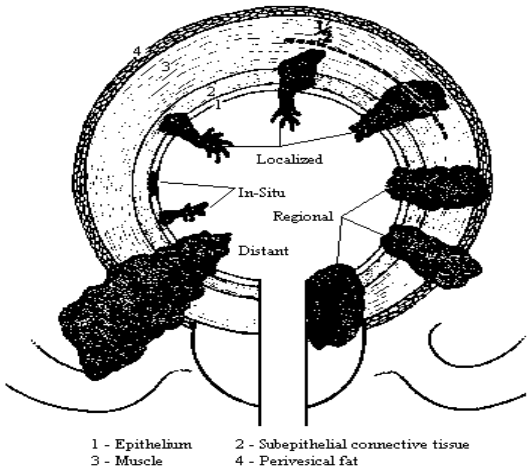


Figure 7 Source: Workbook for Staging of Cancer with modifications

Staging information can be obtained from any of the following:

- Histologic confirmation of tumor, by histologic or urinary cytology;
- Bimanual examination under anesthesia before and after endoscopy;
- Cystoscopy;
- Pyelography;
- Imaging (radiographic and computer assisted);
- Other evaluations to determine metastatic involvement, including CT scans, biochemical studies and isotope studies; or
- Total cystectomy and lymph node resection.

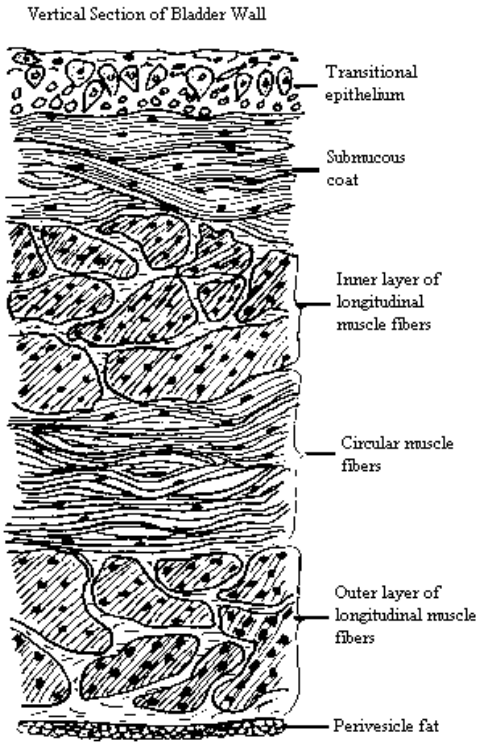


Figure 8 Source: SEER Informational Guidebook, Training Aids

Coding Instructions for Confidential Cancer Reporting Form, continued

1. Cystoscopy was positive on 9-1-97 for transitional cell carcinoma of the bladder. A CT scan of the pelvis noted a bladder tumor extending into perivesical fat. No lymphadenopathy identified. Pathology report from the total cystectomy and lymph node dissection on 9-2-97 noted the tumor extended into the perivesical fat with 4 positive para-aortic lymph nodes all less than 2cm in size.

   Document: 9-1-97 cysto + for trans cell ca. CT Pelv-blddr tmr ext into perivesical fat. 9-2-97 cystectomy-tmr ext into perivesical fat w/4 + para-aortic lns.

2. Biopsies taken during cystoscopic examination on 7-1-97 indicated a tumor of the bladder extending superficially into the subepithelial connective tissue. Bimanual examination revealed enlarged pelvic nodes. Patient underwent a total cystectomy and regional node dissection on 7-2-97. The path report revealed the tumor extended through the bladder wall into surrounding connective tissue and all nodes were negative.

   Document: 7-1-97 cysto-blddr tmr ext superficially into subepi conn tiss. Biman Exm-enlrgd pelv nodes. 7-2-97 cystectomy-tmr ext thru blddr wall into surrounding conn tiss. All lns neg.

3. Patient presented with hematuria. Multiple tumors were removed during cystoscopy on 8-1-97, all positive for Grade II transitional cell carcinoma. No other staging information available.

   Document: 8-1-97 multi tmrs were rmvd during cysto, + for grd II trans cell ca. Other w/u N/A.

4. 75yo male admitted for cystoscopy on 7-20-97 which was positive for transitional cell carcinoma of the bladder. CT of the pelvis noted a large tumor of the bladder with extension to the rectum and probable pathologic common iliac nodes.

   Document: 7-20-97 cysto + trans cell bladder. CT Pelv-lg blddr tmr w/ext to rectum & prob pathologic common iliac nodes.

★ **Breast** (Figure 9 and Figure 10)

Staging information can be obtained from any of the following:

- Physical examination;
- Pathologic examination of breast or other tissue to establish a diagnosis of cancer;
- Operative findings, including the size of tumor, chest wall invasion, and presence or absence of positive nodes and distant metastasis;
- Imaging to establish the extent of cancer. Useful studies: mammogram, chest x-ray, bone scan, metastatic skeletal x-rays, brain scan, liver/spleen scan, CT scans, MRI;

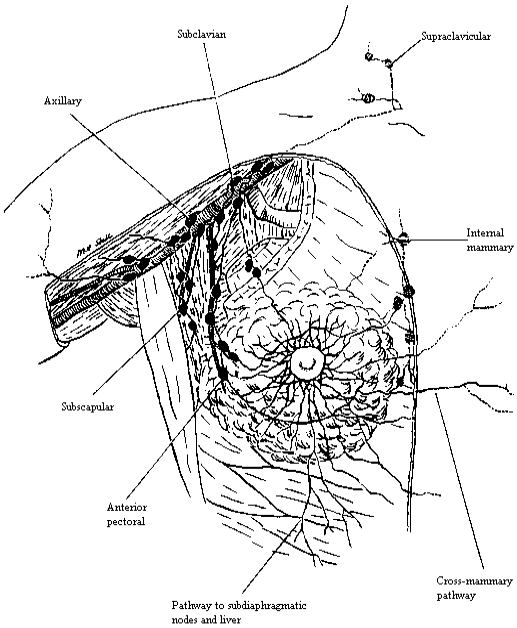


Figure 9 Source: Cancer Patient Data Program, Research and Training, University of California @ San Francisco.

Coding Instructions for Confidential Cancer Reporting Form, continued

- Nodules of tumor in the fat adjacent to the primary tumor are considered regional lymph node metastasis (intramammary nodes); or
- Clusters or clumps of cancer cells found in axillary fat that are not specifically identified as lymph nodes are considered to be axillary lymph nodes that have lost their architectural configuration.

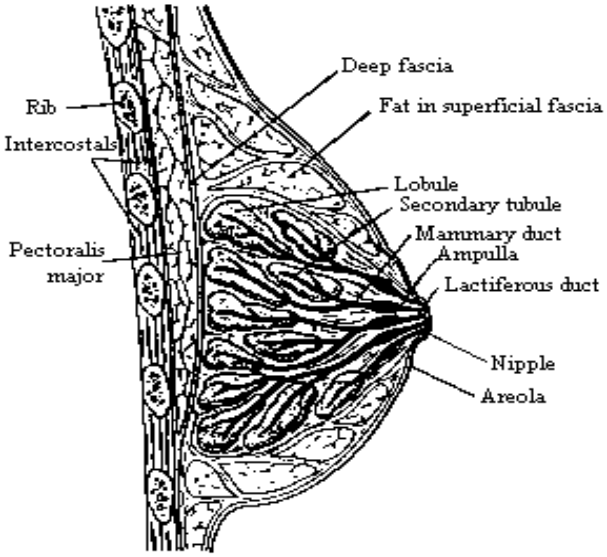


Figure 10 Source: SEER Self Instructional Manual for Tumor Registrars, Book 4

1. Patient was noted to have a 4x4 cm hard mass in the upper inner quadrant of the left breast with skin dimpling and peau d'orange and palpable nodes in the axilla. Biopsy was positive for infiltrating ductal carcinoma, poorly differentiated on 9-20-97. Patient underwent a modified radical mastectomy on 9-20-97. Pathology report noted a 3x3 cm mass with skin infiltration and 4/15 positive lymph nodes all smaller than 1cm.

   Document: hard mass UIQ lf breast w/skin dimpling, peau d'orange & palp nodes in axilla. 9-20-97 path rpt: 3x3cm mass w/skin infiltration & 4/15 + ax nodes.

2. A 2cm lesion in the UOQ of the right breast was noted on physical exam. Right supraclavicular nodes were enlarged. The breast mass was excised and the supraclavicular nodes were biopsied 8-17-97. Both specimens were positive for poorly differentiated infiltrating ductal carcinoma.

   Document: 2cm les RUOQ breast w/enlrgd rt SC nodes. Bx rt breast & SC nodes pos for PD infilt duct ca 8-17-97.

3. Biopsy was positive for intraductal carcinoma of the left breast on 8-15-97, with a small focus of invasive component. Patient underwent a lumpectomy and axillary node dissection on 8-16-97. The lumpectomy was negative for residual disease and all 10 nodes were negative for disease.

   Document: 8-15-97 Bx pos for intraductal ca lf breast w/sm focus of inv. 8-16-97 lumpectomy neg for residual dz, 10 nodes neg.

4. A 2.5cm tumor in the LIQ was noted on physical exam. The pathology report from the biopsy on 7-15-97 showed infiltrating ductal carcinoma. A modified radical mastectomy was performed on 7-15-97. There was no residual tumor at the biopsy site at the time of mastectomy, 3/19 nodes were positive for tumor.

   Document: 7-15-97Bx infilt ductal ca. 7-15-97 MRM-no resid ca. 3/19 node pos for tumor.

Coding Instructions for Confidential Cancer Reporting Form, continued

5. A large 5cm mass of the right upper outer quadrant was noted with no palpable axillary lymphadenopathy. At mastectomy on 8-1-97, the tumor was noted to involve the chest wall and 4/18 positive axillary nodes were positive, the largest of which was greater than 2cm.

   Document: 5cm mss RUOQ. 8-1-97 path-tmr invlvd chest wall, 4/18 nodes +.

★ **Colon** (Figure 11 and Figure 12)

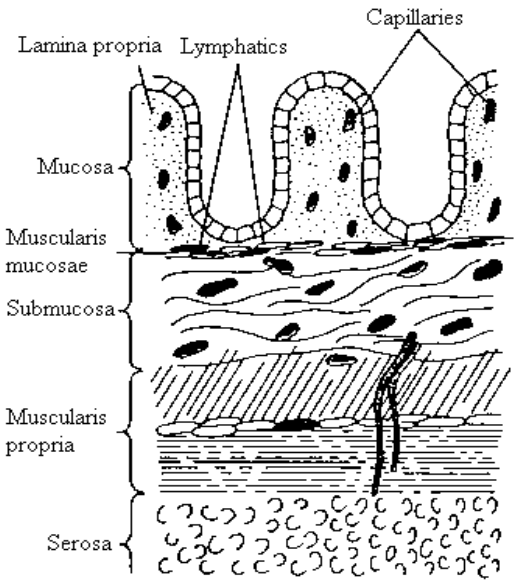


Figure 11

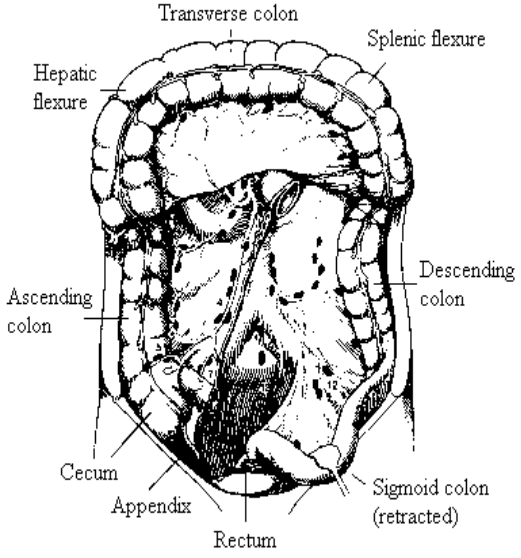


Figure 12 Source: Workbook for Staging of Cancer

NOTE: *The colon is a hollow organ. Staging is based on depth of invasion rather than size of tumor. Look for terms like submucosa, muscularis propria, and serosa.*

Staging information can be obtained from any of the following;

- Physical examination, including digital rectal examination as appropriate;
- Barium enema;
- Endoscopy (sigmoidoscopy, colonoscopy) and biopsy; cystoscopy;
- Evaluations for possible metastasis. Special studies include: chest x-ray, small bowel series, liver/spleen scan, abdominal and pelvic CT scans, MRI, brain and bone scans;
- Pathologic examination of the resected specimen;
- Exploration and surgical observation of the abdomen; or
- Nodules of tumor in pericolic or perirectal fat are considered to be lymph nodes containing metastasis.

1. Segmental resection of the sigmoid colon on 9-1-97 revealed infiltrating grade II adenocarcinoma w/invasion of the serosa and 4 lymph nodes positive for metastasis.

   Document: 9-1-97 Path-infilt grd II adenoca w/inv of serosa & 4 lymph nodes pos.

Coding Instructions for Confidential Cancer Reporting Form, continued

2. Polypectomy specimen on 8-27-97 revealed grade II adenocarcinoma arising in an adenomatous polyp. No invasion of submucosa of the stalk was identified.

   Document: 9-27-97 polypectomy-adenoca arising in adenomatous polyp, no inv of stalk identified.

3. Hemicolectomy on 8-20-97 revealed a grade III infiltrating adenocarcinoma extending into but not through the muscularis propria. At least 20 pericolonic lymph nodes were negative for tumor.

   Document: 8-20-97 path rvld grd 3 adenoca ext into but not thru muscularis propria. 20 pericolonic ln neg for tmr.

4. Adenocarcinoma of the hepatic flexure extending through the bowel wall into adjacent tissue, onto the surface of the liver with 3 of 10 lymph nodes positive for adenocarcinoma on 8-1-97. En bloc resection of the liver revealed metastatic adenocarcinoma of the liver capsule.

   Document: 8-1-97 adenoca hep flex ext thru bowel wall onto surface of liver. 3/10 ln pos. Resection liver rvld mets of liver capsule.

★ **Lung** (Figure 13)

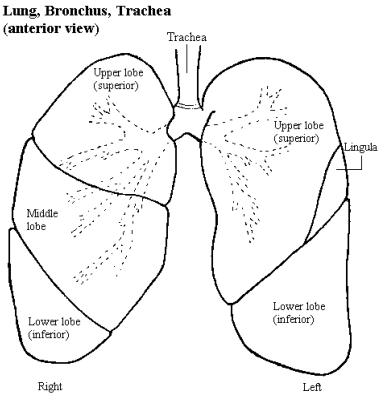


Figure 13 Source: SEER Informational Guidebook Training Aids

Staging information can be obtained from any of the following:

- Physical examination;
- Pathologic examination of primary tumor or other tissue to establish a diagnosis of cancer, such as fine needle biopsy and cytology, sputum cytology, bronchial washings, thoracentesis;
- Imaging, such as chest x-ray, lung scan, CT chest, lung tomography, MRI scan of the lung;
- Endoscopy, such as bronchoscopy, mediastinoscopy, thorascopy;
- Studies to determine presence or absence of positive nodes and distant metastasis. Useful studies include bone scan, brain scan, liver/spleen scan, esophagogram, esophagoscopy, laryngoscopy, and bone marrow biopsy;
- Mediastinotomy;
- Information from thoracotomy; or
- Pathological examination of the resected specimen and lymph nodes.

NOTE: *Assume mediastinal nodes are involved if a mediastinal mass or mediastinal adenopathy are reported on x-ray or mediastinoscopy.*

1. CT scan of the chest noted a small tumor in the right main stem bronchus 3 cm from the carina with negative hilar and mediastinal nodes. Enlarged cervical nodes were noted on physical exam. Biopsy of a cervical node was positive for adenocarcinoma on 9-1-97.

   Document: CT Chest-sm tmr rt mnstm bronchus, neg hilar/mediast nodes. Enlrgd cerv nodes on PE. 9-1-97 bx cerv nodes pos for adenoca.

2. CXR demonstrated a tumor in the left lower lobe of the lung with pleural effusion and positive bilateral paratracheal nodes. Cytology of the pleural fluid on 8-17-97 was positive for squamous cell carcinoma.

   Document: CXR-tmr LLL w/pl eff & pos bil paratrach nodes. 8-17-97 cytology of pl fld pos for SCC.

3. A 3cm tumor was noted on CXR. A lobectomy was performed on 8-17-97 and pathology was positive for a 3.5cm adenocarcinoma of the right lung with microscopic extension to the carina and 4 out of 10 hilar nodes were positive for adenocarcinoma.

   Document: CXR-3cm tmr. 8-17-97 path-3.5cm adenoca Rt lung w/microscopic ext to carina. 4/10 hilar nodes pos.

4. A CT of the chest revealed a 2cm tumor in the right lung with enlarged right subcarinal lymph nodes. Biopsy subcarinal nodes were positive for large cell carcinoma on 8-19-97.

   Document: CT Chest-2cm tmr R lung w/enlrgd R subcarinal lns. 8-19-97 bx SC nodes + for lg cell ca.

5. CXR noted a 2.5cm tumor of the LLL of the lung. The resected specimen from the lobectomy showed invasion of the visceral pleura on 9-16-97. All nodes were negative for tumor.

   Document: CXR-2.5cm tmr LLL. 9-16-97 lobectomy-inv visc pleura. Nodes -.

★ **Prostate** (Figure 14)

Staging information can be obtained from any of the following:

- Proof of malignancy by histology or cytology;
- Digital rectal exam;
- Imaging, including transrectal ultrasound, intravenous pyelogram, kidney-ureter-bladder x-ray, abdominal and/or pelvic CT scans, lymphangiogram, MRI;
- Endoscopy, including cystoscopy, proctosigmoidoscopy;

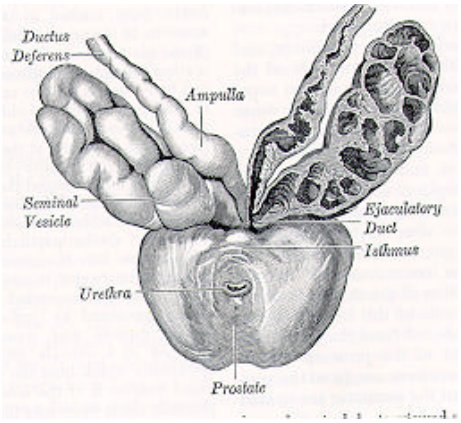


Figure 14

Coding Instructions for Confidential Cancer Reporting Form, continued

- Evaluations for possible metastasis, including chest x-ray, bone scan, metastatic bone survey, brain scan, liver/spleen scan;
- Laboratory tests, including acid phosphatase and prostate-specific antigen (PSA), and other tumor markers as appropriate; or
- Total removal of the prostate and seminal vesicles (prostatoseminalvesiculectomy) as well as a pelvic lymph node dissection.

1. On rectal exam, the prostate was noted to be slightly enlarged without induration. CT of the pelvis was negative. The path report from the TURP on 7-15-97 states: "moderately well differentiated adenocarcinoma of the prostate with slight perineural invasion."

   Document: RE-sl enlrgd prostate w/o induration. CT Pelv-neg. 7-15-97 TURP-mwd adenoca w/sl perineural inv.

2. Patient presented with a nodule occupying more than half a lobe of the prostate but seemed confined to the prostate on rectal exam. A needle biopsy was positive for adenocarcinoma on 5-16-97. The pathology from the radical prostatectomy on 5-16-97 noted extension into the right seminal vesicle. All nodes were negative.

   Document: Nodule occupying > ½ lobe of prost w/o evid of ext outside of prost. 5-16-97 Needle bx + for adenoca. 5-16-97 prostatectomy/lymphadenectomy-ext to R sem ves noted, all nodes -.

Coding Instructions for Confidential Cancer Reporting Form, continued

FIRST COURSE OF TREATMENT (Position 2356-3464)

Cancer-directed therapy or definitive treatment is limited to procedures that normally affect, control, change, remove, or destroy cancer tissue of the primary or metastatic site. The **first course** of treatment is defined as cancer-directed treatment that is administered **within the first FOUR months** after diagnosis or the **first FOUR months** after the date treatment was started. Any and all types of **FIRST COURSE** of definitive treatment administered at the reporting institution or elsewhere should be coded in the appropriate treatment field **and** documented in the **TREATMENT DOCUMENTATION** box.

EXCEPTIONS:

1. *If it is documented that the **planned** first course of therapy continued beyond or began after four months of initiation, include all as first course.*
2. *Should there be a change of therapy due to apparent failure of the original planned and administered treatment or because of the progression of the disease, the later therapy should be **excluded** from the first course and considered part of a **second** course of therapy.*
3. *For patients with a diagnosis of **leukemia**, the basic time period for first course of treatment is **two months** after the date of initiation of therapy. However, disregard all treatment administered to the patient after the lapse of the first remission. If no remission is attained during the first course of therapy, use the two-month rule.*

DATE STARTED (MMDDYYYY) - SURGERY (Position 2356-2363)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day and year of the first cancer-directed surgery. If the exact date of cancer-directed surgery is not available, record an approximate date.

If two or more cancer-directed surgeries are performed, enter the date for the **first** cancer-directed surgery.

EXAMPLE: *A patient was found to have a large polyp during a colonoscopy. Polypectomy(surgery code 26) September 8, 1997 confirmed adenocarcinoma of the descending colon. September 23, 1997 the patient underwent a left hemicolectomy (surgery code 40). The date of surgery would be recorded as 09081997, and the surgery code 40.*

If an incisional biopsy was performed followed by a resection two weeks later, enter the date for the resection as the date started.

EXAMPLE: *October 1, 1997 a patient had a fine needle aspiration of a right breast mass, consistent with infiltrating ductal carcinoma. October 15, 1997, the patient underwent a right modified radical mastectomy (surgery code 50) for Stage II disease. The date of surgery would be recorded as 10151997, and the surgery code 50.*

Coding Instructions for Confidential Cancer Reporting Form, continued

TYPE OF RX - SURGERY (Position 2364-2365)

Cancer-directed surgery is an operative procedure that actually remove, excise, or destroy cancer tissue of primary site or metastatic site. Surgery performed solely for the purpose of establishing a diagnosis/stage (exploratory surgery), the relief of symptoms (bypass surgery), or reconstruction are not considered definitive treatment. Brushings, washings, and aspiration of cells are not surgical procedures.

Guidelines in coding treatment:

1. Document and code site specific surgery found in Appendix H. A patient may have both site specific cancer directed surgery and surgery of regional and/or distant sites. Document all surgical procedures and code the surgery of the primary site. Surgery to remove regional tissue or organs is coded in this field only if the tissue/organs are removed with the primary site in an **en bloc** resection. An en bloc resection is the removal of organs one piece at one time. **The two digit surgery code of the primary site takes precedence over the surgery of regional and/or distant site(s)or distant lymph node(s) one digit code.**

EXAMPLE: A patient has a modified radical mastectomy, the breast and axillary contents are removed in one piece (en bloc), surgery of primary site is coded as a modified radical mastectomy (50) even if pathology finds no nodes in the specimen.

2. In the absence of cancer directed surgery of the primary site, document and code the surgery of regional and distant sites (dissection of regional lymph nodes, dissection of distant lymph nodes, surgery of distant site(s), surgery of distant site with dissection of lymph node(s)) found in Appendix H. A patient may have both a surgical procedure of regional and/or distant site(s) or lymph node(s) and a non cancer-directed procedure. **Document** both and record the one digit surgery code for the regional and/or distant site(s) or lymph node(s).

EXAMPLE: A patient has an incisional bx of a breast primary lesion. Patient elects to have an axillary lymph node dissection and radiation therapy. The axillary node dissection would be documented and coded appropriately in the regional nodes positive and the regional nodes examined fields. The incisional bx is a non cancer-directed procedure and would be documented but not coded.

3. In the absence of both surgical procedures of the primary site and regional and/or distant sites, **document** the non cancer-directed procedure. Code the surgery field *00* (no surgery performed) and leave the date field empty.

<u>* SCLite Users: Code both the surgery of primary site and regional/distant sites appropriately.</u>

Document and code the type of cancer-directed surgery, regardless of whether the surgery was performed at your institution or another institution.

EXAMPLES: mastectomy, hysterectomy, wide excision, excisional biopsy, fulguration

Coding Instructions for Confidential Cancer Reporting Form, continued

If two or more cancer-directed surgeries are performed, record the most comprehensive cancer-directed surgery code with the date of the **first** cancer-directed treatment.

EXAMPLE: *A patient was found to have a large polyp during a colonoscopy. Polypectomy (surgery code 26) September 8, 1997 confirmed adenocarcinoma of the descending colon. September 23, 1997 the patient underwent a left hemicolectomy (surgery code 40). The date of surgery is recorded 09081997, and the surgery code 40.*

If an incisional biopsy was performed followed by a resection two weeks later, record the code of the resection as the cancer-directed surgery.

EXAMPLE: *September 16, 1997 a patient had an incisional biopsy of an enlarged mediastinal lymph node positive for adenocarcinoma of the right lung, September 30, 1997, a partial lobectomy (surgery code 31) and lymph node dissection was performed, both consistent with adenocarcinoma. The date of surgery is recorded 09301997, and the surgery code 31. The lymph node dissection would be documented and the fields for regional lymph nodes positive and regional lymph nodes examined coded appropriately.*

★ **REASON FOR NO CANCER-DIRECTED SURGERY** (Position 2366)

Record the code for the reason no cancer-directed surgery was performed. **(Optional Data Set)**

CODES	DEFINITION
0	Cancer-directed surgery performed. The field "surgery" is coded in the range 10-90 or 1-9.
1	Cancer-directed surgery not recommended for this stage of disease, histologic type or site.
2	Cancer-directed surgery was contraindicated because of other conditions; or autopsy only cases; cases in which cancer-directed surgery would have been the treatment of choice, but could not be performed because of co-morbid (contraindicated) conditions. Cases in which surgery was recommended, but the patient expired before it could be performed.
6	Cancer-directed surgery would have been the treatment of choice; surgery was not performed, but the reason is not given.
7	Cancer-directed surgery was the treatment of choice and recommended by the physician. The patient, patient's guardian or family member refused cancer-directed surgery.
8	Cancer-directed surgery was recommended by a physician; no follow-up information available to confirm if surgery was performed.
9	No cancer-directed surgery know to have been performed; no confirmation if surgery was recommended or performed (frequently non-analytic cases); death certificate-only cases.

Coding Instructions for Confidential Cancer Reporting Form, continued

DATE STARTED - RADIATION (Position 2367-2374)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day and year the **first course** of radiation was initiated. If two or more types of radiation therapy used (i.e., beam and isotopes or beam and implants), record the date of the first type of radiation. If the exact date of radiation therapy is not available, record an approximate date.

TYPE OF RX - RADIATION (Position 2375)

Radiation therapy can be administered from either external (i.e., beam) or internal (i.e., radioactive implants) sources.

EXAMPLES: *centigray (cGy), gamma knife, radioactive implants, I-131, seeds, cesium, radioactive gold*

Document and code the type of radiation whether administered to the primary site or a metastatic site. Include all radiation therapy that are a part of the **first course of treatment**, whether delivered at your institution or another institution.

CODES	DEFINITION
0	No radiation therapy was administered.
1	**Beam radiation:** x-ray, cobalt, linear accelerator, neutron beam, betatron, spray radiation, intraoperative radiation and stereotactic radiosurgery (gamma knife and proton beam).
2	**Radioactive implants:** brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials (cesium, radium, radon, and radioactive gold).
3	**Radioisotopes:** internal use of radioactive isotopes (iodine-131, phosphorus-32, strontium 89 and 90). Radioisotopes can be administered orally, intracavitary, or by intravenous injection.
4	**Combination:** a combination of beam radiation **and** radioactive implants, radioisotopes or both were used.
5	Radiation was administered but the method or source is unknown or not documented.
9	Unknown if radiation therapy was administered.

Coding Instructions for Confidential Cancer Reporting Form, continued

★ **REASON FOR NO RADIATION THERAPY** (Position 2376)

Record the reason no radiation therapy was performed. **(Optional Data Set)**

CODES	DEFINITION
0	Radiation therapy was performed as first course of treatment. The field "radiation" was coded 1-5.
1	Radiation therapy was considered but not recommended as appropriate for this stage of disease, histologic type, or site.
2	Cases in which radiation therapy would have been recommended as part of the treatment plan but could not be performed due to co-morbid (contraindicated) conditions; cases in which radiation therapy was recommended, but the patient expired before radiation was given; or autopsy only cases.
6	Radiation therapy was part of the treatment plan, but it was not done and the reason is not given.
7	Radiation therapy was the treatment of choice and was recommended by a physician. The patient, patient's guardian or family member refused radiation treatment.
8	Radiation therapy was recommended. There is no information on whether the patient received radiation treatment.
9	Available medical records do not state whether radiation therapy was considered, consultation performed, treatment recommended or treatment performed; death certificate-only cases.

DATE STARTED - CHEMOTHERAPY (Position 2377-2384)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day and year the first course of chemotherapy was started. If the exact date of chemotherapy is not available, record an approximate date.

TYPE OF RX - CHEMOTHERAPY (Position 2385)

Chemotherapy is a chemical (or group of chemicals) administered to treat cancer. It does not achieve its affect through hormonal change. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

EXAMPLES: *CHOP, 5-FU, Adriamycin, Bleomycin, Daunorubicin*

> ***NOTE:*** *The Self Instructional Manual for Tumor Registrars, Book 8- Antineoplastic Drugs, that is published by the SEER program, is a* ***recommended reference*** *for the documentation of antineoplastic drugs on the TCR Reporting Form. This resource can be obtained from SEER (refer to page 35 for the mailing address and phone number).*

Coding Instructions for Confidential Cancer Reporting Form, continued

Document and code the type of chemotherapy administered as **first course of treatment**, whether chemotherapy was given at your institution or another institution.

CODES	DEFINITION
0	No chemotherapy was administered.
1	**Chemotherapy, NOS**
2	**Chemotherapy, single agent**
3	**Chemotherapy, multiple agents** (combination regimen)
9	Unknown if chemotherapy administered.

Chemotherapeutic agents may be administered by intravenous infusion or given orally.

Chemotherapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more chemotherapy drugs. The interval of a treatment cycle varies and chemotherapy may be administered for several weeks or several years.

Adjuvant chemotherapy is given after other methods have destroyed the clinically detectable cancer cells. Chemotherapy is given to destroy micrometastasis (undetectable cancer cells). The intent of adjuvant chemotherapy is to prevent or delay a recurrence.

EXAMPLE: *The patient has breast cancer with positive nodes. The patient is clinically free of disease after a modified radical mastectomy. The patient is treated with adjuvant chemotherapy to prevent or delay disease recurrence.*

Multimodality, combined modality or *concurrent* therapy is chemotherapy given before, during or after other treatment modalities (i.e., surgery, radiation) as a part of the treatment plan.

EXAMPLE: *A patient with rectal cancer surgically resected, then undergoes combined radiation therapy and chemotherapy.*

Neo-adjuvant therapy is given prior to surgical resection or radiation therapy to help reduce the bulk of a locally advanced primary cancer.

EXAMPLE: *A patient with locally advanced breast cancer receives chemotherapy to reduce the tumor size. Chemotherapy is followed by a modified radical mastectomy.*

Coding Instructions for Confidential Cancer Reporting Form, continued

★ **REASON FOR NO CHEMOTHERAPY** (Position 2386)

Record the reason no chemotherapy was performed. **(Optional Data Set)**

CODES	DEFINITION
0	Chemotherapy was administered. The field "chemotherapy" was coded 1-3.
1	Chemotherapy is not the method recommended for this stage of disease, histologic type, or site.
2	Cases in which chemotherapy would have been the treatment of choice, but could not be performed because of co-morbid (contraindicated) conditions; cases in which chemotherapy was recommended, but the patient expired before the treatment could begin; or autopsy only cases.
6	Chemotherapy would have been the treatment of choice but was not administered; the reason is not documented.
7	Chemotherapy was the treatment of choice and was recommended by a physician. The patient, patient's guardian or family member refused chemotherapy.
8	Chemotherapy was recommended by a physician; no follow-up information available to confirm if chemotherapy was administered.
9	No confirmation if chemotherapy was recommended or administered (frequently non-analytic cases); death certificate-only cases.

DATE STARTED - HORMONE THERAPY (Position 2387-2394)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day and year the first course of hormone therapy was initiated. If the exact date of hormone therapy started is not available, record an approximate date.

TYPE OF RX - HORMONE/STEROID (ENDOCRINE) THERAPY (Position 2387-2394)

Hormone therapy is administered to treat cancer tissue and which is considered to achieve its effect through change of the hormone balance. Some tissues, such as prostate or breast, depend upon hormones to develop. When a malignancy arises in these tissues, it is usually hormone responsive. Other primaries and histologic types may be hormone responsive, such as melanoma and hypernephroma. Hormonal therapy may effect a long-term control of the cancer growth. It is usually not used to "cure" the cancer.

EXAMPLES: *Tamoxifen; orchiectomy for prostate cancer; oophorectomy for breast cancer; radiation to ovaries for breast cancer or testicles for prostate cancer*

Coding Instructions for Confidential Cancer Reporting Form, continued

Document and code the type of hormone therapy the patient received as part of the **first course of treatment**, whether the patient received the hormones at your institution or another institution.

CODES	DEFINITION
0	No hormone was administered.
1	**Hormonal therapy** (including NOS and antihormones).
2	**Endocrine surgery** and/or **endocrine radiation therapy** (ie., oophorectomy for breast cases; orchiectomy for prostate cases).
3	**Combination** of 1 and 2.
9	Unknown if hormonal therapy administered.

Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

> ***EXCEPTION:*** *When prednisone or other hormone is administered for other reasons, do not code as hormone therapy.*

Decadron is coded as definitive cancer treatment for **leukemias**, **lymphomas**, and **multiple myelomas**. ***Decadron*** is administered in order to achieve its effect on cancer tissue through change of the hormone balance. It is coded for **other sites** only when stated to be **cancer directed treatment**.

EXAMPLES: *A patient has advanced lung cancer with multiple metastasis to the brain. The physician orders decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormone therapy.*

A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Do not code the prednisone as hormone therapy.

Coding Instructions for Confidential Cancer Reporting Form, continued

★ **REASON FOR NO HORMONE THERAPY** (Position 2396)

Record the reason no hormone therapy was performed. **(Optional Data Set)**

CODES	DEFINITION
0	Hormone therapy was given.
1	Hormone therapy is not the method recommended for this stage of disease, histology or site.
2	Cases in which hormone therapy would have been the treatment of choice, but could not be administered because of co-morbid (contraindicated) conditions; cases in which hormone therapy was recommended, but the patient expired before therapy was administered; or autopsy only cases.
6	Hormone therapy would have been the treatment of choice, but was not administered the reason is not documented.
7	Hormone therapy was the treatment of choice and was recommended by the physician. The patient, patient's guardian or family member refused hormone therapy.
8	Hormone therapy was recommended, but no information is available about whether the patient received hormones.
9	No confirmation if hormone therapy was recommended or administered (frequently non-analytic cases); death certificate-only cases.

DATE STARTED - BIOLOGICAL RESPONSE MODIFIER (BRM) (Position 2397-2404)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day and year the first course of BRM (immunotherapy) was started. If the exact date of BRM is not available, record an approximate date.

TYPE OF RX - BRM (Position 2405)

Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to the tumor cells.

EXAMPLES: *BCG, Bone marrow transplant, C-Parvum, Interferon, Interleukin, Levamisole, MVE-2, Pyran copolymer, Thymosin, Vaccine therapy, Virus therapy*

Coding Instructions for Confidential Cancer Reporting Form, continued

Document and code the BRM the patient received as part of the **first course of treatment**, whether the BRM was given at your institution or another institution.

CODES	DEFINITION
0	No biological response modifier was administered.
1	Biological response modifier
2*	Bone marrow transplant - autologous
3*	Bone marrow transplant - allogeneic
4*	Bone marrow transplant, NOS
5*	Stem cell transplant
6*	Combination of 1 and any 2, 3, 4, or 5
7	Patient or patient's guardian refused BRM
8	BRM recommended, unknown if administered
9	No confirmation if BRM was recommended or performed; unknown if BRM administered.

NOTE: *Codes 2-6 are effective for cases diagnosed 1996 and forward.*

DATE STARTED - OTHER (Position 2406-2413)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day and year the first course of other treatment was started. If the exact date of other treatment is not available, record an approximate date.

TYPE OF RX - OTHER (Position 2414)

"Other treatment" includes therapies designed to modify or control the cancer cells that are not defined in "Surgery", "Radiation", "Chemotherapy", or "Hormone Therapy" fields. This includes experimental, unproven, or newly developed methods.

EXAMPLES: *Laetrile, Krebiozen, Hyperthermia, Arterial block for renal carcinoma*

Do **NOT** code ancillary drugs in this field. There is no coding scheme for ancillary drugs.

EXAMPLES: *Allopurinol, G-CSF (growth stimulating factor), Epogen, Neupogen*

Coding Instructions for Confidential Cancer Reporting Form, continued

CODES	DEFINITION
0	All cancer-directed therapy was coded in other treatment fields; the patient received no cancer-directed therapy
1	Other cancer-directed therapy; cancer-directed therapy that cannot be appropriately assigned to other specific treatment codes. For example: Hyperbaric oxygen (as adjunct to cancer-directed treatment) or hyperthermia.
2	Other experimental cancer-directed therapy (not included elsewhere)
3	Double-blind study, code not yet broken
6	Unproven therapy (including laetrile, krebiozen, etc.)
7	Patient or patient's guardian refused therapy which would have been coded 1-3 above
8	Other cancer-directed therapy recommended, unknown if administered
9	Unknown if other cancer-directed therapy administered

TREATMENT DOCUMENTATION (Position 2415-3464)

Text information to support cancer diagnosis, stage and treatment codes should be provided by facilities without a *documented data quality program* such as one approved by the American College of Surgeons. Document any and all types of **first course** definitive treatment administered regardless of where the treatment was received (at the reporting institution or another facility) along with the date the treatment was received or began.

Also, document in this section if the medical record indicates no treatment was given (0's entered for Type of Treatment) or if there is no information in the medical record that definitive treatment was given (9's entered for Type of Treatment).

If it cannot be determined whether an intended therapy was actually performed, record that it was recommended but it is not known if the procedure was administered. For example, "chemotherapy recommended; unknown if given," (8 entered for Type of Treatment).

★ **DATE OF LAST CONTACT OR DATE OF DEATH** (MMDDYYYY) (Position 3465-3472)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day, and year (MMDDYYYY) of the date of last contact or if patient deceased, record the date of death. Record the date last seen at your facility or date of last contact from follow up information on the patient. If patient is known to be deceased but date of death is not available, the vital status should be coded alive (1) and the date of last contact should be recorded in this field. Under the Other Pertinent Information text area, document the patient is deceased and the date of death is not

available. The TCR will research the Bureau of Vital Statistics death files to obtain date of death.

Coding Instructions for Confidential Cancer Reporting Form, continued

★ **VITAL STATUS** (Position 3473)

Code the patient's vital status as of the date recorded in the "Date of Last Contact or Death" field. Use the most current and accurate information available.

Codes:

0 Dead
1 Alive

★ **CAUSE OF DEATH** (Position 3474-3477)

The underlying cause of death should be coded if an ICD-9 code is available. Central registries are the primary users of this data item. The TCR will update the cause of death when death clearance matching for reporting completeness is performed.

> **If an ICD-9 code is not available, this field can be left blank**. **Document the cause of death in the Other Pertinent Information text area to enable the TCR to code this field accurately.**

Codes:

0000 Patient alive at last follow-up
7777 State death certificate or listing not available
7797 State death certificate or listing available, but underlying cause of death not coded

DATE ABSTRACTED (MMDDYYYY) (Position 3479-3486)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day, full year the form was completed.

ABSTRACTED BY (Position 3487-3489)

Record the initials of the abstractor.

APPENDIX a

Texas Cancer Incidence Reporting Act

Chapter 82, Health and Safety Code, as amended by Chapter 14,
Acts of the 75th Legislature, effective May 31, 1997.
(formerly Vernon's Ann. Civ. St. art. 4477-40)

Section 82.001. Short Title

This Chapter may be cited as the Texas Cancer Incidence Reporting Act.

Section 82.002. Definitions

In this chapter:

(1) "Cancer" includes:
  (A) a large group of diseases characterized by uncontrolled growth and spread of abnormal cells;
  (B) any condition of tumors having the properties of anaplasia, invasion, and metastasis;
  (C) a cellular tumor the natural course of which is fatal; and
  (D) malignant neoplasm.

(2) "Cancer treatment center" means a special health facility devoted to the study, prevention, diagnosis, and management of neoplastic and allied diseases.

(3) "Clinical Laboratory" means an accredited facility in which:
  (A) tests are preformed identifying findings of anatomical changes; and
  (B) specimens are interpreted and pathological diagnoses are made.

(4) "Hospital" means:
  (A) a general or special hospital licensed under Chapter 241 (Texas Hospital Licensing Law); or
  (B) The University of Texas System Cancer Center.

(5) "Precancerous disease" means abnormality of development and organization of adult cells, which is a condition of early cancer without the invasion of neighboring tissue.

(6) "Tumorous disease" means a new growth of tissue in which the multiplication of cells is uncontrolled and progressive, also called neoplasm. It is a swelling, enlargement, or abnormal mass, either benign or malignant, that performs no useful functions.

Section 82.003. Applicability of Chapter

This chapter applies to records of cases of precancerous and tumorous diseases specified by the board and all cases of cancer, diagnosed on or after January 1, 1979, and to records of all ongoing cases of those diseases diagnosed before January 1, 1979.

Section 82.004. Registry Required

The board shall maintain a cancer registry for the state.

Section 82.005. Content of Registry

(a) The cancer registry must be a central data bank of accurate, precise, and current information that medical authorities agree serves as an invaluable tool in the early recognition, prevention, cure, and control of cancer and specified precancerous and tumorous diseases.

(b) The cancer registry must include:
  (1) a record of the cases of precancerous and tumorous diseases specified by the board and of cancer that occur in the state; and
  (2) information concerning those cases as the board considers necessary and appropriate for the recognition, prevention, cure, or control of those diseases.

Section 82.006. Board Powers

To implement this chapter, the board may:

(1) adopt rules that the board considers necessary;

(2) execute contracts that the board considers necessary;

(3) receive the data from medical records of cases of cancer or precancerous or tumorous disease that in the custody or under the control of clinical laboratories, hospitals, and cancer treatment centers to record and analyze the data directly related to those diseases;

(4) compile and publish statistical and other studies derived from the patient data obtained under this chapter to provide, in an accessible form, information that is useful to physicians, other medical personnel, and the general

public;

Chapter 82, Health and Safety Code, as amended by Chapter 14,
Acts of the 75th Legislature, effective May 31, 1997, Continued

(5) comply with requirements as necessary to obtain federal funds in the maximum amounts and most advantageous proportions possible;
(6) receive and use gifts made for the purpose of this chapter; and
(7) limit cancer reporting activities under this chapter to specified geographic areas of the state to ensure optimal use of funds available for obtaining the data.

Section 82.007. Annual Report

(a) The department shall publish an annual report to the legislature of the information obtained under this chapter.
(b) The department, in cooperation with other cancer reporting organizations and research institutions, may publish reports the department determines are necessary or desirable to carry out the purpose of this chapter.

Section 82.008. Data From Medical Records

(a) To ensure an accurate and continuing source of data concerning precancerous and tumorous diseases specified by the board and concerning cancer, each hospital, clinical laboratory, and cancer treatment center shall furnish to the board or its representative, on request, data the board considers necessary and appropriate that is derived from each medical record of a case of one of those diseases that is in the custody or under the control of the hospital, laboratory, or treatment center.
(b) A hospital, clinical laboratory, or cancer treatment center shall furnish the data requested under Subsection (a) in a format prescribed by the department.
(c) The data required to be furnished under this section must include patient identification and diagnosis.
(d) The board by rule may determine a reasonable amount for compensation to the hospital, clinical laboratory, or cancer treatment center for the cost of collecting or furnishing the data and shall pay that amount, within the limits of funds appropriated expressly for that purpose.
(e) The data required to be furnished under this section may also be furnished only to cancer registries of hospitals.

Section 82.009. Confidentiality

(a) Data obtained under this chapter directly from the medical records of a patient is for the confidential use of the department and the persons or public or private entities that the board determines are necessary to carry out the intent of this chapter. The data is privileged and may not be divulged or made public in a manner that discloses the identity of an individual whose medical records have been used for obtaining data under this chapter.
(b) Information that may identify an individual whose medical records have been used for obtaining data under this chapter is not available for public inspection under Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-17a, Vernon's Texas Civil Statutes).
(c) Statistical information collected under this chapter is public information.
(d) Data furnished to a hospital cancer registry under Section 82.008 (e) is for the confidential use of the hospital cancer registry and is subject to Subsection (a).

Section 82.010. Immunity From Liability

The following persons subject to this chapter that act in compliance with this chapter are not civil or criminally liable for furnishing the information required under this chapter:
(1) a hospital, clinical laboratory, or cancer treatment center;
(2) an administrator, officer, or employee of a hospital, clinical laboratory, or cancer treatment center; and
(3) a physician.

Section 82.011. Examination and Supervision Not Required

This chapter does not require an individual to submit to any medical examination or supervision or to examination or supervision by the board or its representatives.

APPENDIX B

Texas Cancer Registry
Transmittal Form

INSTRUCTIONS FOR COMPLETING TRANSMITTAL FORM

The information on the Transmittal Form (TF) TCR #2 assists the TCR in processing reported data. Enclose a TF whenever you submit data (electronically or paper), unless you submit data by modem. Modem transmissions are the only transmission in which a TF does not need to be submitted. A separate TF does not need to be completed for each accession year.

ELECTRONIC SUBMISSIONS *AND* REPORTING FORMS:

FROM: Record the name and address of the reporting institution.

DATE SENT: Record month, day, and year.

CONTACT PERSON: Record name, title, and department.

PHONE: List area code, number, and extension.

REPORTING FORMS:

YEAR OF ADMISSION: Record the year(s) for which forms are being submitted.

TOTAL FORMS SENT: Record the actual number of forms submitted.

TOTAL MEDICAL RECORDS SENT: Record the actual number of copies of medical records submitted.

ALL FORMS SUBMITTED FOR YEAR: Indicate whether or not casefinding and abstracting have been completed for a registry year.

COMMENTS: Record any pertinent comments.

Original TF

TF Example

APPENDIX C

Confidential Cancer Incidence Reporting Form

Original abstract

Example 1

Example 2

Example 3

Example 4

Example 5

APPENDIX D

Texas FIPS
County Codes

FIPS COUNTY CODES - TEXAS COUNTIES

Anderson	001	Comal	091	Grayson	181
Andrews	003	Comanche	093	Gregg	183
Angelina	005	Concho	095	Grimes	185
Aransas	007	Cooke	097	Guadalupe	187
Archer	009	Coryell	099	Hale	189
Armstrong	011	Cottle	101	Hall	191
Atascosa	013	Crane	103	Hamilton	193
Austin	015	Crockett	105	Hansford	195
Bailey	017	Crosby	107	Hardeman	197
Bandera	019	Culberson	109	Hardin	199
Bastrop	021	Dallam	111	Harris	201
Baylor	023	Dallas	113	Harrison	203
Bee	025	Dawson	115	Hartley	205
Bell	027	Deaf Smith	117	Haskell	207
Bexar	029	Delta	119	Hays	209
Blanco	031	Denton	121	Hemphill	211
Borden	033	De Witt	123	Henderson	213
Bosque	035	Dickens	125	Hidalgo	215
Bowie	037	Dimmitt	127	Hill	217
Brazoria	039	Donley	129	Hockley	219
Brazos	041	Duval	131	Hood	221
Brewster	043	Eastland	133	Hopkins	223
Briscoe	045	Ector	135	Houston	225
Brooks	047	Edwards	137	Howard	227
Brown	049	Ellis	139	Hudspeth	229
Burleson	051	El Paso	141	Hunt	231
Burnet	053	Erath	143	Hutchinson	233
Caldwell	055	Falls	145	Irion	235
Calhoun	057	Fannin	147	Jack	237
Callahan	059	Fayette	149	Jackson	239
Cameron	061	Fisher	151	Jasper	241
Camp	063	Floyd	153	Jeff Davis	243
Carson	065	Foard	155	Jefferson	245
Cass	067	Fort Bend	157	Jim Hogg	247
Castro	069	Franklin	159	Jim Wells	249
Chambers	071	Freestone	161	Johnson	251
Cherokee	073	Frio	163	Jones	253
Childress	075	Gaines	165	Karnes	255
Clay	077	Galveston	167	Kaufman	257
Cochran	079	Garza	169	Kendall	259
Coke	081	Gillespie	171	Kenedy	261
Coleman	083	Glasscock	173	Kent	263
Collin	085	Goliad	175	Kerr	265
Collingsworth	087	Gonzales	177	Kimble	267
Colorado	089	Gray	179	King	269

Kinney	271	Panola	365	Upshur	459
Kleberg	273	Parker	367	Upton	461
Knox	275	Parmer	369	Uvalde	463
Lamar	277	Pecos	371	Val Verde	465
Lamb	279	Polk	373	Van Zandt	467
Lampasas	281	Potter	375	Victoria	469
La Salle	283	Presidio	377	Walker	471
Lavaca	285	Rains	379	Waller	473
Lee	287	Randall	381	Ward	475
Leon	289	Reagan	383	Washington	477
Liberty	291	Real	385	Webb	479
Limestone	293	Red River	387	Wharton	481
Lipscomb	295	Reeves	389	Wheeler	483
Live Oak	297	Refugio	391	Wichita	485
Llano	299	Roberts	393	Wilbarger	487
Loving	301	Robertson	395	Willacy	489
Lubbock	303	Rockwall	397	Williamson	491
Lynn	305	Runnels	399	Wilson	493
McCulloch	307	Rusk	401	Winkler	495
McLennan	309	Sabine	403	Wise	497
McMullen	311	San Augustine	405	Wood	499
Madison	313	San Jacinto	407	Yoakum	501
Marion	315	San Patricio	409	Young	503
Martin	317	San Saba	411	Zapata	505
Mason	319	Schleicher	413	Zavala	507
Matagorda	321	Scurry	415		
Maverick	323	Shackelford	417	Unknown	999
Medina	325	Shelby	419		
Menard	327	Sherman	421		
Midland	329	Smith	423		
Milam	331	Somervell	425		
Mills	333	Starr	427		
Mitchell	335	Stephens	429		
Montague	337	Sterling	431		
Montgomery	339	Stonewall	433		
Moore	341	Sutton	435		
Morris	343	Swisher	437		
Motley	345	Tarrant	439		
Nacogdoches	347	Taylor	441		
Navarro	349	Terrell	443		
Newton	351	Terry	445		
Nolan	353	Throckmorton	447		
Nueces	355	Titus	449		
Ochiltree	357	Tom Green	451		
Oldham	359	Travis	453		
Orange	361	Trinity	455		
Palo Pinto	363	Tyler	457		

APPENDIX E

Texas Public Health Regions

Texas Department of Health

Public Health Regions

APPENDIX F

Bilateral Sites

BILATERAL SITES

Laterality codes of "1" - "9" must be used for the following bilateral sites:

Adrenal gland
Bones, pelvic (excluding sacrum, coccyx, and symphysis pubis)
Bones, skin, joints, nerves, and soft tissue of limbs
Bones, skin, joints, nerves, and soft tissue of shoulder and hip
Breast
Carotid body
Epididymis
Eye
Fallopian tube
Frontal sinus
Kidney, NOS
Lung
Main bronchus (excluding carina)
Maxillary sinus
Middle ear
Nasal cavity (excluding nasal cartilage, nasal septum)
Ovary
Parotid gland
Pleura
Renal Pelvis
Rib, Clavicle (excluding sternum)
Skin of other and unspecified parts of face (midline code "9")
Skin of external ear
Skin of eyelid
Skin of trunk (midline code "9")
Spermatic cord
Sublingual gland
Submandibular gland
Testis
Tonsil, NOS
Tonsillar pillar
Tonsillar fossa
Ureter

APPENDIX G

Criteria for Determining Multiple Primaries

Criteria for Determining Multiple Primaries (excluding lymphatic and hematopoietic diseases)

Every effort should be made to identify separate primary tumors. The determination of the number of primary tumors a patient has is a medical decision, but operational rules are needed in order to ensure consistency of reporting by all institutions. Basic factors include the site of origin, the date of diagnosis, the histologic type, and the behavior of the neoplasm.

In general, if there is a difference in the site where the tumor originates, it is fairly easy to determine whether it is a separate primary, regardless of dates of detection and of differences in histology.

Likewise, if there is a clear cut difference in histology, other data such as site and time of detection are not essential. In some neoplasms, however, one must be careful since different histologic terms are used to describe progressive stages or phrases of the same disease process.

The following definitions and rules are used to determine the number of independent primary tumors:

Definitions:

1. Site differences: For colon, anus and anal canal, bone, peripheral nerves and autonomic nervous system, connective tissue, and melanoma of the skin, each subcategory (4-characters) as delineated in the ICD-O-2, is considered to be a separate site. The site groups shown in the table on page G - iii are each to be considered one site when determining multiples. For all other sites, each category (3-characters) as delineated in ICD-O is considered to be a separate site.

   EXAMPLES:

   a. Transverse colon (C18.4) and descending colon (C18.6) are to be considered separate sites.
   b. Base of tongue (C01.9) and border of tongue (C02.1) are considered subsites of the tongue and would be treated as one site - either overlapping lesion of parts of the tongue (C02.8) or tongue, NOS (C02.9)
   c. Trigone of urinary bladder (C67.0) and lateral wall of urinary bladder (C67.2) are considered to be subsites of the urinary bladder and would be treated as one site - either overlapping lesion of subsites of the bladder (C67.8) or bladder, NOS (C67.9).

   Each side of a paired organ is considered to be a separate site unless stated to be metastatic, with the exceptions of bilateral involvement of the ovaries in which a single histology is reported, bilateral retinoblastomas, and bilateral Wilms' tumors.

2. Histologic type: Differences in histologic type refer to differences in the **first three** digits of the morphology code as found in ICD-O, except for lymphatic and hematopoietic diseases.

3. Simultaneous/Synchronous: Diagnoses within two months of each other.

Criteria for Determining Multiple Primaries (excluding lymphatic and hematopoietic diseases), continued

The following ICD-O-2 codes are to be considered one primary site when determining multiple primaries:

ICD-0 Codes	Site Groupings	ICD-0 Codes	Site Groupings
C01	Base of tongue	C51	Vulva
C02	Other and unspecified parts of tongue	C52	Vagina
		C57.7	Other specified female genital organs
		C57.8-.9	Unspecified female genital organs
C05	Palate	C56	Ovary
C06	Other and unspecified parts of mouth	C57.0	Fallopian tube
		C57.1	Broad ligament
		C57.2	Round ligament
		C57.3	Parametrium
		C57.4	Uterine adnexa
C07	Parotid gland	C60	Penis
C08	Other/unspecified major salivary glands	C63	Other/unspecified male genital organs
C09	Tonsil	C64	Kidney
C10	Oropharynx	C65	Renal pelvis
		C66	Ureter
		C68	Other and unspecified urinary organs
C12	Pyriform sinus	C74	Adrenal gland
C13	Hypopharynx	C75	Other endocrine glands/ related structures
C23	Gallbladder		
C24	Other/unspecified parts of biliary tract		
C30	Nasal cavity and middle ear		
C31	Accessory sinuses		
C33	Trachea		
C34	Bronchus and lung		
C37	Thymus		
C38.0	Heart		
C38.1-.3	Mediastinum		
C38.8	Overlapping lesion of heart, mediastinum and pleura		
C38.4	Pleura		

Criteria for Determining Multiple Primaries (excluding lymphatic and hematopoietic diseases), continued

The following rules should be used to determine if a single or multiple primary should be reported. If further clarification is needed, please consult the SEER Program Code Manual or call your appropriate regional program.

Rules:

The following are considered **one** primary and **one** abstract should be prepared:

A single lesion with one histologic type is considered **one** primary.

EXAMPLE: *An adenocarcinoma (8140/3) of the ascending colon (C18.2) is considered **one** primary and **one** abstract should be prepared.*

A single lesion with multiple histologic types is considered **one** primary.

EXAMPLE: *One lesion with both a transitional cell carcinoma **AND** a squamous cell carcinoma in the right renal pelvis is considered **one** primary and **one** abstract should be prepared.*

A new cancer with the same histology as one diagnosed previously, in the same site, within two months, is considered **one** primary.

A carcinoma with a specific term and a carcinoma with a non-specific term within the same site are considered **one** primary.

EXAMPLE: *Mucinous adenocarcinoma (8481/3) AND adenocarcinoma, NOS (8140/3) in the transverse colon. This is considered **one** primary and **one** abstract should be prepared.*

Papillary and/or transitional cell carcinomas of the bladder are considered one primary, regardless of the number of times it may recur.

EXAMPLE: *A patient was diagnosed 10 years ago with transitional cell carcinoma (TCC) of the bladder. They are admitted 9/17/97 for TURB of a suspicious looking lesion on the dome. Pathology was positive for (TCC). This is considered **one** primary and **one** abstract should be prepared.*

NOTE: *If the first occurrence of TCC was reported by your institution, no abstract is required for the second occurrence of TCC. However, if the first occurrence was NOT reported by your facility, according to reporting requirements, an abstract **must** be completed.*

Kaposi's sarcoma (9140/3) is considered **one** primary, regardless of the number of occurrences.

EXAMPLE: *A patient is diagnosed with a Kaposi's sarcoma on the right cheek and the lower leg. This would be considered **one** primary and **one** abstract should be prepared.*

Criteria for Determining Multiple Primaries (excluding lymphatic and hematopoietic diseases), continued

Within each breast, combinations of ductal and lobular carcinoma occurring simultaneously are to be considered **one** primary and the histology coded accordingly.

NOTE: *If the ductal lesion occurs in one breast and the lobular occurs in the other breast, consider this* ***separate*** *primaries and another abstract should be completed.*

The following are considered **separate** primaries and **more than one** abstract should be prepared:

A new cancer with the same histology diagnosed in the same site after two months are considered **separate** primaries (unless stated to be recurrent or metastatic).

EXAMPLE: *Squamous cell carcinoma LUL of lung diagnosed 6/15/97. Admitted 10/30/97 for biopsy of a suspicious looking lesion which revealed squamous cell carcinoma. With no mention of recurrent or metastatic disease, this case would be considered* ***separate*** *primaries and another abstract should be completed.*

Multiple lesions of the same histologic type occurring in different sites are considered **separate** primaries (unless stated to be metastatic).

Multiple lesions of different histologic types within a single site whether occurring simultaneously or at different times are considered **separate** primaries.

EXAMPLE: *Hypernephroma (8312/3)* ***AND*** *a separate lesion consistent with Wilm's tumor (8960/3) in the left kidney would be considered* ***separate*** *primaries and another abstract should be completed.*

EXCEPTIONS:

* A carcinoma with a specific term and a carcinoma with a non-specific term within the same site, prepare **one** abstract. For example, mucinous adenocarcinoma (8481/3) and adenocarcinoma (8140/3).

* When both an adenocarcinoma (81403) and an adenocarcinoma (in situ) in a(n) (adenomatous) polyp (8210) or an adenocarcinoma (in situ) in a villous adenoma (8261, 8263) arise in the same segment of the colon or of the rectum, prepare one abstract with a histology coded to adenocarcinoma (8140/3).

* Within each breast, combinations of ductal and lobular carcinoma occurring simultaneously are to be considered a single primary and the histology coded accordingly. If the ductal lesion occurs in one breast and the lobular lesion occurs in the opposite breast, consider these to be two primaries.

When there are multiple tumors of different histologic types occurring in different sites, are considered separate primaries (whether occurring simultaneously or at different times).

Criteria for Determining Multiple Primaries (excluding lymphatic and hematopoietic diseases), continued

EXAMPLE: *Adenocarcinoma (8140/3) in the pylorus of the stomach (C164) AND small cell carcinoma (8041/3) in the left lower lobe of the lung (C343) would be considered* ***separate*** *primaries and another abstract should be completed.*

If each side of a paired site is involved, consider this **separate** primaries, unless stated to be metastatic.

EXAMPLE: *A patient is diagnosed with an adenocarcinoma in the right upper lobe of the lung and an adenocarcinoma in the left lower lobe of the lung would be considered* ***separate*** *primaries and two abstracts should be completed.*

NOTE: *Consult Appendix F for a list of bilateral sites. What appears to be a bilateral site, may not be. For example, the thyroid has right and left lobes, but there is only one thyroid.*

EXCEPTIONS:

The following should be considered one primary, regardless of laterality:

* Bilateral Wilm's tumors (kidney)
* Bilateral ovarian tumors (ovary) (in which there is only one histology involved)
* Bilateral retinoblastomas (eye)

If there is an in-situ followed by an invasive cancer in the same site more than two months apart, report as two primaries even if noted to be a recurrence.

EXAMPLE: *A patient was diagnosed 7/11/97 with ductal carcinoma in-situ UIQ left breast. In January 1998, physical exam revealed a palpable lesion in the UIQ left breast. Biopsy of this lesion was consistent with an invasive ductal carcinoma. This would be considered* ***separate*** *primaries and another abstract should be completed.*

Criteria for Determining Multiple Primaries of Lymphatic and Hematopoietic Diseases

The following rules are to be used as a guide in identifying lymphomas and leukemias with second primaries. Note that the rules are in terms of general headings followed by the ICD-O morphology codes included in each heading. For specific terms such as "histiocytic," "diffuse," "nodular" and "granulocytic," check the ICD-O Alphabetic List to determine into which general category a specific term falls. Complete instructions for determining subsequent primaries in lymphatic and hematopoietic diseases are available in both the SEER Program Code Manual and the ROADS.

(1) Hodgkin's disease (9650-9667)	
Report as a second primary	***Do not report as a second primary***
Non-Hodgkin's lymphoma (9591-9595, 9670-9686, 9690-9698, 9702-9714) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761) Any leukemia (9800-9940)	Malignant lymphoma, NOS (9590) Hodgkin's disease (9650-9667)

(2) Malignant lymphoma, NOS (9590)	
Report as a second primary	***Do not report as a second primary***
Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) Mast cell tumor (9740, 9741) Acute leukemia, NOS (9801) Non-lymphocytic leukemias (9840-9842, 9860-9910) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	Malignant lymphoma, NOS (9590) Non-Hodgkin's lymphoma (9591-9595, 9670-9686, 9702-9714) Hodgkin's disease (9650-9667) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Waldenstrom's macroglobulinemia (9761) Leukemia, NOS (9800) Chronic leukemia, NOS (9803) Plasma cell leukemia (9830) Lymphoid or lymphocytic leukemia (9820-9827)

Criteria for Determining Multiple Primaries of Lymphatic and Hematopoietic Diseases, continued

(3) Non-Hodgkin's lymphoma (9591-9595, 9670-9686, 9690-9698, 9711-9714)	
Report as a second primary	***Do not report as a second primary***
Hodgkin's disease (9650-9667) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720-9722) Mast cell tumor (9740, 9741) Acute leukemia, NOS (9801) Non-lymphocytic leukemias (9840-9842, 9860-9910) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940)	Malignant lymphoma, NOS (9590) Non-Hodgkin's lymphoma (9591-9595, 9670-9686, 9690-9698, 9702-9714) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Waldenstrom's macroglobulinemia (9761) Leukemia, NOS (9800) Chronic leukemia, NOS (9803) Lymphoid or lymphocytic leukemia (9820-9827) Plasma cell leukemia (9830) Lymphosarcoma cell leukemia (9850)

(4) Burkitt's lymphoma (9687)	
Report as a second primary	***Do not report as a second primary***
Non-Hodgkin's lymphoma (9593-9594, 9670-9686, 9690-9698, 9702-9714) Hodgkin's disease (9650-9667) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761) Acute leukemia, NOS unless specified as Burkitt's type (9801) Chronic leukemia, NOS (9803) Chronic lymphocytic leukemia (9823) Plasma cell leukemia (9830) Non-lymphocytic leukemias (9840-9842, 9860- 9910) Lymphosarcoma cell leukemia (9850) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	Malignant lymphoma, NOS (9590, 9591, 9595) Lymphosarcoma (9592) Burkitt's lymphoma (9687) Burkitt's leukemia (9826) Lymphoid/lymphocytic leukemia (9820-9822, 9824, 9825, 9827)

Criteria for Determining Multiple Primaries of Lymphatic and Hematopoietic Diseases, continued

(5) Cutaneous and peripheral T-cell lymphomas (9700-9709)	
Report as a second primary	***Do not report as a second primary***
Non-Hodgkin's lymphoma (9593-9594, 9670-9687, 9690-9698, 9711-9714) Hodgkin's disease (9650-9667) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstorm's macroglobulinemia (9761) Lymphoid or lymphocytic leukemia specified as B-cell (9820-9827) Plasma cell leukemia (9830) Non-lymphocytic leukemia (9840-9842, 9860-9910) Lymphosarcoma cell leukemia (9850) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	Malignant lymphoma, NOS (9590, 9591, 9595) Lymphosarcoma (9592) Cutaneous and peripheral T-cell lymphomas (9700-9709) Leukemia, NOS (9800) Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) *Lymphoid or lymphocytic leukemia (9820-9827) *Unless specifically identified as B-cell

(6) Malignant histiocytosis or Letterer-Siwe's disease or true histiocytic lymphoma (9720, 9722, 9723)	
Report as a second primary	***Do not report as a second primary***
Non-Hodgkin's lymphoma (9592-9594, 9670-9686, 9690-9698, 9702-9714) Hodgkin's disease (9650-9667) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761) Leukemia except hairy cell and leukemic reticuloendotheliosis (9800-9932)	Malignant lymphoma, NOS (9590, 9591, 9595) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Hairy cell leukemia (9940) Leukemic reticulendotheliosis (9941)

Criteria for Determining Multiple Primaries of Lymphatic and Hematopoietic Diseases, continued

(7) Plasmacytoma or multiple myeloma (9731, 9732)	
Report as a second primary	***Do not report as a second primary***
*Non-Hodgkin's lymphoma (9592-9594, 9670, 9672-9676, 9683, 9685, 9686, 9690-9697, 9702-9713) Hodgkin's disease (9650-9667) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Mast cell tumor (9740, 9741) Leukemia except plasma cell (9800-9827, 9840-9941) *Except immunoblastic or large cell lymphoma	Malignant lymphoma, NOS (9590, 9591, 9595) *Immunoblastic or large cell lymphoma (9671, 9680-9682, 9684, 9698, 9714) Plasmacytoma or multiple myeloma (9731, 9732) Waldenstrom's macroglobulinemia (9761) Plasma cell leukemia (9830) *Occasionally, multiple myeloma develops an immunoblastic or large cell lymphoma phase. Report the cases as multiple myeloma and as one primary.

(8) Mast cell tumor (9740, 9741)	
Report as a second primary	*Do not report as a second primary*
Non-Hodgkin's lymphoma (9590-9594, 9670-9687, 9690-9698, 9702-9704) Hodgkin's disease (9650-9667) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer-Siwe's disease (9720-9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Waldenstrom's macroglobulinemia (9761) Chronic lymphocytic leukemia (9823) Plasma cell leukemia (9830) Non-lymphocytic leukemias (9840-9842, 9860-9880, 9910) Lymphosarcoma cell leukemia (9850) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	Mast cell tumor (970, 9741) Leukemia, NOS (9800) Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) Monocytic leukemia (9890-9894) Mast cell leukemia (9900)

Criteria for Determining Multiple Primaries of Lymphatic and Hematopoietic Diseases, continued

(9) Waldenstrom's macroglobulinemia (9761)	
Report as a second primary	*Do not report as a second primary*
Non-Hodgkin's lymphoma except immunoblastic or large cell lymphoma (9593-9594, 9673-9677, 9683, 9685-9686, 9690-9697, 9702-9713) Hodgkin's disease (9650-9667) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) Malignant histiocytosis or Letterer Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Mast cell tumor (9740, 9741) Leukemia except plasma cell (9800-9827, 9840-9941)	Malignant lymphoma, NOS (9590, 9591, 9595) Lymphosarcoma (9592) Malignant lymphoma, lymphocytic (9670, 9672) Immunoblastic or large cell lymphoma (9671, 9680-9682, 9684, 9698, 9714) Plasmacytoma or multiple myeloma (9731, 9732) Waldenstrom's macroglobulinemia (9761) Plasma cell leukemia (9830)

(10) Leukemia, NOS (9800)	
Report as a second primary	***Do not report as a second primary***
Non-Hodgkin's lymphoma (9590-9594, 9670-9687, 9690-9698, 9702-9714) Hodgkins disease (9650-9667) Mycosis fungoides (9700) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761)	Sezary's disease (9701) Any leukemia* (9800-9941) ****NOTE:*** Leukemia, NOS (9800) should be upgraded to a more specific leukemia diagnosis (higher number) when it is found but not considered a second primary.

(11) Acute leukemia, NOS (9801)	
Report as a second primary	***Do not report as a second primary***
Non-Hodgkin's lymphoma (9590-9594, 9670-9687, 9690-9698, 9702-9714) Hodgkin's disease (9650-9667) Mycosis fungoides (9700) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761)	Sezary's disease (9701) Any leukemia* (9800-9941) ****NOTE:*** Acute leukemia, NOS (9801) should be upgraded to a more specific leukemia diagnosis (higher number) when it is found but not considered a second primary.

Criteria for Determining Multiple Primaries of Lymphatic and Hematopoietic Diseases, continued

(12) Chronic leukemia, NOS (9803)	
Report as a second primary	***Do not report as a second primary***
Hodgkin's disease (9650-9667) Malignant histiocytosis or Letterer-Siwe's disease (9720, 9722) Mast cell tumor (9740, 9741)	Non-Hodgkin's lymphoma (9590-9594, 9670-9686, 9690-9698, 9702-9714) Burkitt's lymphoma (9687) Mycosis fungoides or Sezary's disease (9700, 9701) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Waldenstrom's macroglobulinemia (9761) Any leukemia* (9800-9941) ****NOTE:*** Chronic leukemia, NOS (9803) should be upgraded to a more specific leukemia diagnosis (higher number) when it is found but not considered a second primary.

APPENDIX H

Site-Specific Cancer-Directed Surgery Codes

NOTE: *At the time of printing, the newly revised surgery codes were not available. This appendix will be mailed separately as soon as it has been received and can be printed.*

APPENDIX I

Common Abbreviations

COMMON ACCEPTABLE ABBREVIATIONS

(in order of terms)

When abbreviating words in an address, refer to the Address Abbreviations section of the *National Zip Code and Post Office Directory*, published by the U.S. Postal Service. For short names of antineoplastic drugs, consult the SEER Program *Self Instructional Manual for Tumor Registrars: Book 8-- Antineoplastic Drugs, 3rd Edition*.

Other accepted abbreviations are:

Abdomen	ABD	Bilateral Salpingo-oophorectomy	BSO
Abdominal Perineal	AP	Bile Duct	BD
Above Knee Amputation	AK(A)	Biological Response Modifier	BRM
Acid Phosphatase	ACID PHOS	Biopsy	BX
Acquired Immunodeficiency		Blood Urea Nitrogen	BUN
Syndrome	AIDS	Bone Marrow	BM
Acute Granulocytic Leukemia	AGL	Bone Scan	BSC
Acute Lymphocytic Leukemia	ALL	Bowel Movement	BM
Acute Myelogenous Leukemia	AML	Bowel Sounds	BS
Adenocarcinoma	ADENOCA	Breath Sounds	BS, BRS
Adjacent	ADJ	Bright Red Blood (per Rectum)	BRB(PR)
Admission; Admit	ADM	Calcium	CA
Against Medical Advice	AMA	Carcinoembryonic Antigen	CEA
Aids Related Complex	ARC	Carcinoma	CA
Alcohol	ETOH	Carcinoma In-situ	CIS
Alkaline Phosphatase	ALK PHOS	CAT Scan	CT, CT SC
Alpha-fetoprotein	AFP	Centimeter	CM
Also Known As	AKA	Central Nervous System	CNS
Ambulatory	AMB	Cerebrospinal Fluid	CSF
Anaplastic	ANAP	Cervical Intraepithelial	
Angiography	ANGIO	Neoplasia	CIN
Anterior	ANT	Cervical Vertebra	C1-C7
Anteroposterior	AP	Cervix	CX
Appendix	APP	Cesium	CS
Approximately	APPROX	Chemotherapy	CHEMO
Arteriovenous	AV	Chest X-ray	CXR
Aspiration	ASP	Chief Complaint	CC
Auscultation & Percussion	A&P	Chronic Granulocytic Leukemia	CGL
Autopsy	AUT	Chronic Lymphocytic Leukemia	CLL
Axilla(ry)	AX	Chronic Myelogenous Leukemia	CML
Bacillus Calmette-Guerin	BCG	Cigarettes	CIG
Barium	BA	Clear	CLR
Barium Enema	BE	Ascending Colon	A-COLON
Bartolin's, Urethral, and		Descending Colon	D-COLON
Skene's Glands	BUS	Sigmoid Colon	S-COLON
Below Knee (Amputation)	BK(A)	Transverse Colon	T-COLON
Benign Prostatic		Common Bile Duct	CBD
Hypertrophy/Hyperplasia	BPH	Complaining of	C/O
Bilateral	BIL	Complete Blood Count	CBC

Computerized Axial Tomography	CT, CAT SCAN
Consistent with	C/W
Continue	Cont
Costal Margin	CM
Cubic Centimeter	CC
Cystoscopy	CYSTO
Cytology	CYTO
Cytomegalovirus	CMV
Date of Birth	DOB
Dead on Arrival	DOA
Decreased	DECR (or <)
Dermatology	DERM
Diagnosis	DX
Diameter	DIAM
Differentiated	DIFF
Dilatation & Curettage	D&C
Discharge	D I S , DISCH, DS
Discontinued	DC
Disease	DZ, DIS
Doctor	DR, MD
Ears, Nose & Throat	ENT
Electroencephalogram	EEG
Electromyogram	EMG
Emergency Room	ER
Endoscopic Retrograde Cholangiopancreatography	ERCP
Enlarged	ENL
Esophagogastroduodenoscopy	EGD
Estrogen Receptor (Assay)	ER(A)
Evaluation	EVAL
Examination	EXAM
Examination under Anesthesia	EUA
Excision	EXC
Exploratory Laparotomy	EXP LAP
Extend	EXT
Extended Care Facility	ECF
Extension	EXT
External	EXT
Extremity	EXT
Eyes, Ears, Nose, & Throat	EENT
Family (Medical) History	F(M)H
Fever Unknown Origin	FUO
Finger breadth	FB
Floor of Mouth	FOM
Follow-up	FU
Fracture	FX
Frozen Section	FS
Gallbladder	GB
Gastroenterostomy	GE
Gastroesophageal	GE
Gastrointestinal	GI
Genitourinary	GU
Grade	GR
Gram	GM
Gynecology	GYN
Head, Eyes, Ears, Nose, and Throat	HEENT
Hematocrit	HCT
Hemoglobin	HGB
History	HX
History & Physical	H&P
History of	HO
History of Present Illness	HPI
Hormone	HORM
Hospital	HOSP
Hour, Hours	HR, HRS
Human Chorionic Gonadotropin	HCG
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Human T-Lymphotrophic Virus Type III	HTLV-III
Hysterectomy	HYST
Immunoglobulin	IG
Impression	IMP
Includes, Including	INCL
Increase	INCR (or >)
Inferior Vena Cava	IVC
Infiltrating	INFILT
Inpatient	IP
Intercostal Margin	ICM
Internal Mammary Artery	IMA
Intrathecal	IT
Intravenous	IV
Intravenous Pyelogram	IVP
Iodine	I
Jugular Venous Distention	JVD
Kidneys, Ureters, Bladder	KUB
Kilogram	KG
Kilovolt	KV
Laparotomy	LAP
Large	LG
Last Menstrual Period	LMP
Lateral	LAT
Left	L, LT
Left Costal Margin	LCM
Left Lower Extremity	LLE
Left Lower Lobe	LLL
Left Lower Quadrant	LLQ
Left Salpingo-oophorectomy	LSO

Left Upper Extremity	LUE	Operation	OP
Left Upper Lobe	LUL	Operative Report	OP RPT
Left Upper Quadrant	LUQ	Ounce	OZ
Liter	L	Outpatient	OP
Liver, Kidney, Spleen (Bladder)	LKS(B)	Packs per Day	PPD
Local M.D.	LMD	Palpated (-able)	PALP
Lower Extremity	LE	Papanicolaou Smear	PAP
Lower Inner Quadrant	LIQ	Papillary	PAP
Lower Outer Quadrant	LOQ	Past Medical History	PMH
Lumbar Puncture	LP	Pathology	PATH
Lumbar Vertebra	L1-L5	Patient	PT
Lumbosacral	LS	Pelvic Inflammatory Disease	PID
Lymphadenopathy-Associated Virus	LAV	Percussion & Auscultation	P&A
		Percutaneous	PERC
Lymph Node(s)	LN, LN'S, LNS	Personal (Primary) Medical Doctor	PMD
		Physical Examination	PE
Magnetic Resonance Imaging	MRI	Platelets	PLT
Malignant	MALIG, MAL	Poorly Differentiated	PD, POOR DIFF
Mandible	MAND	Positive	POS (or +)
Mastectomy	MAST	Positron Emission Tomography	PET
Maxillary	MAX	Possible	POSS
Maximum	MAX	Posterior	POST
Medical Doctor	DR, MD	Posteroanterior	PA
Medicine	MED	Postmortem Examination	POST
Metastatic, Metastasis	MET, METS	Postoperative (-ly)	PO, POSTOP
Microscopic	MICRO	Postoperative Day	POD
Midclavicular Line	MCL	Preoperative (-ly)	PREOP
Middle Lobe	ML	Present Illness	PI
Millicurie (hours)	MC(H)	Prior to Admission	PTA
Milligram (hours)	MG(H)	Probable (-ly)	PROB
Milliliter	ML	Progesterone Receptor (Assay)	PR(A)
Millimeter	MM	Pulmonary	PULM
Moderate	MOD	Pulmonary Artery	PA
Moderately Differentiated	MD, MOD DIFF	Radiation	RAD
		Radiation Absorbed Dose	RAD
Modified Radical Mastectomy	MRM	Radiation Therapy	RT
Nausea & Vomiting	N&V	Radical	RAD
Neck Vein Distention	NVD	Radioimmunoassay	RIA
Negative	NEG (or -)	Radium	RA
Neurology	NEURO	Red Blood Cells	RBC
No Evidence of Disease	NED	Resection	RESEC
No Evidence of Metastatic Disease	NEMD	Respiratory	RESP
Normal	NL	Review of Systems	ROS
No Significant Findings	NSF	Right	R, RT
Not Applicable	NA	Right Costal Margin	RCM
Not Otherwise Specified	NOS	Right Lower Extremity	RLE
Not Recorded	NR	Right Lower Lobe	RLL
Obstructed (-ing, -ion)	OBST	Right Lower Quadrant	RLQ
Operating Room	OR	Right Middle Lobe	RML

Right Salpingo-oophorectomy	RSO
Right Upper Extremity	RUE
Right Upper Lobe	RUL
Right Upper Quadrant	RUQ
Rule Out	RO, R/O
Sacral Vertebra	S1-S5
Salpingo-oophorectomy	SO
Serum Glutamic Oxaloacetic Transaminase	SGOT
Serum Glutamic Pyruvic Transaminase	SGPT
Shortness of Breath	SOB
Skilled Nursing Facility	SNF
Specimen	SPEC
Split Thickness Skin Graft	STSG
Small	SM, SML
Small Bowel	SB, SML BWL
Cervical Spine	C-SPINE
Lumbar Spine	L-SPINE
Sacral Spine	S-SPINE
Thoracic Spine	T-SPINE
Squamous	SQ, SQUAM
Status Post	S/P
Subcutaneous	SUBQ, SQ
Superior Vena Cava	SVC
Symptoms	SX
Thoracic	T
Thoracic Vertebra	T1-T12
Total Abdominal Hysterectomy-Bilateral Salpingo-oophorectomy	TAH-BSO
Total Parenteral Nutrition	TPN
Total Vaginal Hysterectomy	TVH
Transitional Cell Carcinoma	TCC
Transurethral Resection	TUR
Transurethral Resection Bladder (Tumor)	TURB(T)
Transurethral Resection of Prostate	TURP
Treatment	RX, TX
Tumor Size	TS
Undifferentiated	UNDIFF
Upper Extremity	UE
Upper Gastrointestinal	UGI
Upper Inner Quadrant	UIQ
Upper Outer Quadrant	UOQ
Vagina, Vaginal	VAG
Vaginal Hysterectomy	VAG HYST
Vaginal Intraepithelial Neoplasia	VAIN
Vascular	VASC
Vulvar Intraepithelial Neoplasia	VIN
Well Differentiated	WD, WELL DIFF
White Blood Cells	WBC
With	With or C
Within Normal Limits	WNL
Without	W/O
Work-up	W/U
X-ray	XR
Year	YR

SYMBOLS

At	@
Comparison	/
Decrease, Less than	<
Equals	=
Increase, More than	>
Negative	-
Number*	#
Positive	+
Pounds**	#
Times	x

*If it appears before a numeral.
**If it appears after a numeral.

APPENDIX J

Spanish/Hispanic Surnames

INSTRUCTIONS FOR USING 1980 CENSUS LIST OF SPANISH SURNAMES

Attached is the 1980 Census List of Spanish Surnames. This list can be used to code last names in most areas of the United States.

1. All names are listed alphabetically in upper-case letters without any blanks or spaces. For example, names such as "De Leon", "De la Torre", or "La Luz" are shown as "DELEON", "DELATORRE", or "LALUZ".

2. Spanish surnames often have accent marks (ű) or a tilde (~) over the n. Disregard accent marks or tildes as these marks have been omitted from the list. For example, the names "Martinez" and "Nunez" are listed as "MARTINEZ" and "NUNEZ".

3. If a surname consists of two names, separated by a dash or a space, code the person as Spanish if either name appears on the list. For example, for "Collins-Garcia", check "COLLINS" on the list. Since it does not appear, check for "GARCIA". If the name appeared as "Garcia-Collins", then "GARCIA" would be checked first.

4. If the surname is of the form "Lopez R. ", ignore the initial and look up the name, "LOPEZ".

5. If the surname consists of two surnames separated by "de" such as "Perez de Seda", first look up the name written first, i.e., "PEREZ"; if it is not on the list, look up the final name including the word "de", i.e., "DESEDA"; if it is still not on the list, look up the final name without the word "de", i.e., "SEDA".

    a. Surnames written with spaces which begin "de", "de la", or "del", such as "de la Cruz", should be looked up with and without the prefix words, i.e., "CRUZ", "LACRUZ", and "DELACRUZ". If any of the combinations is listed, the surname should be considered Spanish

November, 1994

Spanish/Hispanic surnames

APPENDIX K

SEER Geocodes

SEER Geocodes
Alphabetical List

A

585 Abyssinia
629 Aden
583 Afars and Issas
638 Afghanistan
500 Africa
570 Africa, East
510 Africa, North
540 Africa, South
545 Africa, South West
530 Africa, West
037 Alabama
091 Alaska
481 Albania
224 Alberta
513 Algeria
250 America, Central
---- America, North (use more specific term)
300 America, South
121 American Samoa
641 Andaman Islands
443 Andorra
543 Angola
245 Anguilla
665 Annam
245 Antigua
245 Antilles, Netherlands
625 Arab Palestine
629 Arabia, Saudi
629 Arabian Peninsula
365 Argentina
087 Arizona
071 Arkansas
633 Armenia (U.S.S.R.)
611 Armenia (Turkey)
245 Aruba
600 Asia, NOS
680 Asia, East
640 Asia, Mid-East
610 Asia, Near-East
650 Asia, Southeast
620 Asian-Arab countries
634 Asian Republics of the U.S.S.R, other
109 Atlantic/Caribbean area, other U.S. possessions
100 Atlantic/Caribbean area, U.S. possessions
711 Australia
711 Australian New Guinea
436 Austria
633 Azerbaidzhan S.S.R.
445 Azores

B

247 Bahamas
629 Bahrain
443 Balearic Islands
645 Bangladesh
245 Barbados
245 Barbuda
545 Basutoland
431 Bavaria
545 Bechuanaland
541 Belgian Congo
433 Belgium
252 Belize
539 Benin
246 Bermuda
456 Bessarabia
643 Bhutan
452 Bohemia
355 Bolivia
545 Bophuthatswana
673 Borneo
545 Botswana
341 Brazil
226 British Columbia
331 British Guiana
252 British Honduras
245 British Virgin Islands
671 Brunei
454 Bulgaria
649 Burma
579 Burundi
457 Byelorussian S.S.R.

C

543 Cabinda
245 Caicos Islands
097 California
663 Cambodia
539 Cameroon
220 Canada
110 Canal Zone
443 Canary Islands
122 Canton Islands
545 Cape Colony
445 Cape Verde Islands
245 Caribbean Islands, other
123 Caroline Islands
711 Cartier Islands
633 Caucasian Republics of the U.S.S.R.
245 Cayman Islands
539 Central African Republic
250 Central America
060 Central Midwest States
647 Ceylon
520 Chad
401 Channel Islands (British)
361 Chile
681 China (NOS)
665 China, Cochin
682 China, People's Republic of
684 China, Republic of
723 Christmas Island
545 Ciskel
665 Cochin China
711 Cocos (Keeling) Islands
311 Columbia
083 Colorado
540 Comoros
226 Columbia, British
022 Columbia, District of
539 Conga-Brazzaville
541 Congo-Leopoldville
541 Congo, Belgian
539 Congo, French
007 Connecticut
124 Cook Islands
441 Corsica

256 Costa Rica
471 Crete
453 Croatia
241 Cuba
245 Curaco
495 Cyprus
517 Cyrenaica
452 Czechoslovakia

D

539 Dahomey
453 Dalmatia
017 Delaware
425 Denmark
022 District of Columbia
583 Djibouti
449 Dobruja
245 Dominica
243 Dominican Republic
673 Dutch East Indies
332 Dutch Guiana

E

570 East Africa
680 East Asia
431 East Germany
673 East Indies, Dutch
645 East Pakistan
345 Ecuador
519 Egypt
410 Eire
254 El Salvador
125 Ellice Islands
122 Enderbury Islands
401 England
539 Equatorial Guinea
585 Eritrea
458 Estonia S.S.R (Estonia)
585 Ethiopia
499 Europe, NOS
470 Europe, other mainland

F

420 Faeroe Islands
300 Falkland Islands
431 Federal Republic of Germany
539 Fernando Poo
721 Fiji
429 Finland
035 Florida
684 Formosa
721 Fortuna
441 France
539 French Congo
333 French Guiana
725 French Polynesia
583 French Somaliland
245 French West Indies

G

539 Gabon
345 Galapagos Islands
539 Gambia
033 Georgia (U.S.A.)
633 Georgia (U.S.S.R.)
430 Germanic countries
431 German Democratic Republic
431 Germany
431 Germany, East
431 Germany, Federal Republic
431 Germany, West
539 Ghana
485 Gibraltar
125 Gilbert Islands
471 Greece
210 Greenland
245 Grenada
245 Grenadines, The
245 Guadeloupe
126 Guam
251 Guatemala
401 Guernsey
331 Guiana, British
332 Guiana, Dutch
333 Guiana, French
539 Guinea
539 Guinea-Bissau
539 Guinea, Equatorial
---- Guinea, New (See New Guinea)
539 Guinea, Portuguese
331 Guyana

H

242 Haiti
099 Hawaii
432 Holland
253 Honduras
252 Honduras, British
683 Hong Kong
475 Hungary

I

421 Iceland
081 Idaho
061 Illinois
641 India
045 Indiana
673 Indies, Dutch East
660 Indochina
673 Indonesia
053 Iowa
637 Iran
627 Iraq
410 Ireland
404 Ireland, Northern
400 Isle of Man
631 Israel
583 Issas
447 Italy
539 Ivory Coast

J

244 Jamaica
423 Jan Mayen
693 Japan
673 Java
401 Jersey
631 Jewish Palestine
127 Johnston Atoll
625 Jordan
453 Jugoslavia

K

539 Kameroon
663 Kampuchea
065 Kansas
634 Kazakh S.S.R.
047 Kentucky

575 Kenya

634 Kirghiz S.S.R.
---- Kiribati (code to specific island group)
695 Korea
695 Korea, North
695 Korea, South
629 Kuwait

L

221 Labrador
661 Laos
459 Latvian S.S.R. (Latvia)
623 Lebanon
545 Lesotho
539 Liberia
517 Libya
437 Liechtenstein
128 Line Islands, Southern
461 Lithuanian S.S.R. (Lithuania)
073 Louisiana
434 Luxembourg

M

686 Macao
686 Macau
453 Macedonia
555 Madagascar
445 Maderia Islands
002 Maine
555 Malagasy Republic
551 Malawi
671 Malay Peninsula
671 Malaysia
640 Maldives
520 Mali
491 Malta
224 Manitoba
129 Mariana Islands
221 Maritime provinces, Canada
131 Marshall Islands
245 Martinique
021 Maryland
005 Massachusetts
520 Mauritania
540 Mauritius
540 Mayotte
490 Mediterranean islands, other
721 Melanesian Islands
230 Mexico
041 Michigan
723 Micronesian Islands
640 Mid-East Asia
132 Midway Islands
052 Minnesota
240 Miquelon
039 Mississippi
063 Missouri
449 Moldavia (Romania)
456 Moldavian S.S.R. (U.S.S.R.)
441 Monaco
691 Mongolia
056 Montana
453 Montenegro
245 Montserrat
452 Moravia
511 Morocco
080 Mountain States
553 Mozambique
629 Muscat

N

545 Namibia
133 Nampo-shoto, Southern
545 Natal
723 Nauru
610 Near-East Asia
067 Nebraska
643 Nepal
432 Netherlands
245 Netherlands Antilles
332 Netherlands Guiana
085 Nevada
221 New Brunswick
725 New Caledonia
001 New England
673 New Guinea, except Australian and North East
711 New Guinea, Australian
711 New Guinea, North East
003 New Hampshire
721 New Hebrides
008 New Jersey
086 New Mexico
011 New York
715 New Zealand
221 Newfoundland
555 Nicaragua
520 Niger
531 Nigeria
715 Niue
711 Norfolk Island
510 North Africa
---- North America (use more specific term)
240 North American islands
671 North Borneo (Malaysia)
025 North Carolina
040 North Central States
054 North Dakota
711 North East New Guinea
695 North Korea
010 North Mid-Atlantic States
404 Northern Ireland
129 Northern Mariana Islands
050 Northern Midwest States
549 Northern Rhodesia
225 Northwest Territories (Canada)
423 Norway
998 Not United States, NOS
221 Nova Scotia
551 Nyasaland

O

043 Ohio
075 Oklahoma
629 Oman
223 Ontario
545 Orange Free State
095 Oregon
403 Orkney Islands

P

120 Pacific area, U.S. Possessions
090 Pacific Coast States
720 Pacific Islands
---- Pacific Islands, Trust Territory of the (code to specific island)

639 Pakistan
645 Pakistan, East
639 Pakistan, West
625 Palestine, Arab
631 Palestine, Jewish
257 Panama
711 Papua New Guinea
371 Paraguay
014 Pennsylvania
629 People's Democratic Republic of Yemen
682 People's Republic of China
637 Persia
351 Peru
675 Philippine Islands
675 Philippines
725 Pitcairn
451 Poland
725 Polynesian Islands
445 Portugal
539 Portuguese Guinea
224 Prarie Provinces, Canada
221 Prince Edward Island
543 Principe
101 Puerto Rico

Q

629 Qatar
222 Quebec

R

684 Republic of China
545 Republic of South Africa
540 Reunion
006 Rhode Island
547 Rhodesia
549 Rhodesia, Northern
547 Rhodesia, Southern
539 Rio Muni
440 Romance-language countries
449 Romania
449 Roumania
577 Ruanda
449 Rumania
455 Russia
455 Russia S.F.S.R.
457 Russian, White
577 Rwanda
134 Ryukyu Islands

S

520 Sahara, Western
121 Samoa, American
725 Samoa, Western
245 St. Christopher-Nevis
540 St. Helena
245 St. Lucia
240 St. Pierre
245 St. Vincent
447 San Marino
543 Sao Tome
447 Sardinia
224 Saskatchewan
629 Saudi Arabia
420 Scandinavia
403 Scotland
539 Senegal
453 Serbia
540 Seychelles
403 Shetland Islands
651 Siam
447 Sicily
539 Sierra Leone
643 Sikkim
671 Singapore
450 Slavic countries
453 Slavonia
452 Slovakia
453 Slovenia
721 Solomon Islands
581 Somali Republic
581 Somalia
581 Somaliland
583 Somaliland, French
540 South Africa
545 South Africa, Republic of
545 South Africa, Union of
300 South America
026 South Carolina
055 South Dakota
020 South Mid-Atlantic States
545 South West Africa
650 Southeast Asia
030 Southeastern States
128 Southern Line Islands
070 Southern Midwest States
133 Southern Nampo-shoto
547 Southern Rhodesia
629 Southern Yemen
---- Soviet Union (see individual republics)
443 Spain
520 Spanish Sahara
520 Sri Lanka
673 Sudan
332 Sudanese countries
423 Svalbard
135 Swan Islands
545 Swaziland
427 Sweden
435 Switzerland
621 Syria

T

634 Tadzhik S.S.R.
684 Taiwan
571 Tanzania
571 Tanzanyika
571 Tanganyika
031 Tennessee
077 Texas
651 Thailand
685 Tibet
245 Tobago
539 Togo
136 Tokelau Islands
725 Tonga
665 Tonkin
625 Trans-Jordan
545 Transkei
545 Transvaal
449 Transylvania
245 Trinidad
517 Tripoli
517 Tripolitania
629 Trucial States
515 Tunisia
611 Turkey
634 Turkmen S.S.R.
245 Turks Islands
125 Tuvalu

U

573 Uganda
456 Ukraine
456 Ukrainian S.S.R.
404 Ulster
545 Union of South Africa
---- Union of Soviet Socialist Republics (U.S.S.R.) (see individual republics)
629 United Arab Emirates
519 United Arab Republic
400 United Kingdom
000 United States
102 U.S. Virgin Islands
999 Unknown
520 Upper Volta
375 Uruguay
579 Urundi
084 Utah
634 Uzbek S.S.R.

V

721 Vanuatu
440 Vatican City
545 Venda
321 Venezuela
004 Vermont
665 Vietnam
245 Virgin Islands (British)
102 Virgin Islands (U.S.)
023 Virginia

W

137 Wake Island
402 Wales
449 Wallachia
721 Wallis
093 Washington (state)
022 Washington, D.C.
530 West Africa
431 West Germany
---- West Indies (see individual islands)
639 West Pakistan
024 West Virginia
520 Western Sahara
725 Western Samoa

457 White Russia
051 Wisconsin
082 Wyoming

Y

629 Yemen
629 Yemen, People's Democratic Republic of
453 Yugoslavia
225 Yukon Territory

Z

541 Zaire
549 Zambia
571 Zanzibar
547 Zimbabwe

Appendix L

Comparison of Data Sets

COMPARISON OF DATA SETS

Definitions

Required Data Set (R) - Commission-approved programs must record the required data set items using the codes and definitions specified in the ROADS manual.
Supplementary Data Set (S) - The supplementary data set contains additional data items that are important for the efficient operation of a cancer registry.
Optional Data Set (O) - The optional data set includes items that may be of interest to specific institutions or groups.
Surveillance, Epidemiology, and End Results Program (SEER) - Required data elements for a central registry affiliated with the National Cancer Institute's SEER Program.
National Program of Cancer Registries (NPCR) - Required and recommended data elements for state cancer registries participating in the National Program of Cancer Registries of the Centers for Disease Control and Prevention.

Required elements beginning with 1998 cases.

An (X) indicates the item is part of the data set. *At the time of publication, it is unknown if the organization will collect this data item.

ITEM	COC			SEER	NPCR			TCR		
	R	S	O		R	S	O	R	S	O
PATIENT IDENTIFICATION										
Institution ID number (required for participants in multiple-hospital registries)	X					X		X		
Accession number	X			X		X		X		
Tumor record number				X		X		X		
Sequence number	X			X	X			X		
Year first seen for this primary	X									
Medical record number	X					X		X		
Social Security number	X				X			X		
Military medical record number suffix		X				X				
Name prefix			X							
Name suffix		X						X_2		
Last name	X				X			X		
First name	X				X			X		
Middle name	X				X			X_2		
Maiden name		X				X		X_2		
Alias		X				X		X_2		
Marital status at diagnosis			X	X		X				

ITEM	COC			SEER	NPCR			TCR		
	R	S	O		R	S	O	R	S	O
Patient addr (number and street) at diagnosis	X				X			X		
City/town at diagnosis	X				X			X		
State at diagnosis	X				X			X		
Postal code at diagnosis	X				X			X		
County at diagnosis	X			X	X			X		
Patient address (number and street) - current	X									
City/town - current	X									
State - current	X									
Postal code - current	X									
County current			X							
Census tract			X	X	X			X		
Census coding system			X	X	X					
Telephone	X									
Place of birth			X	X		X		X_2		
Date of birth	X			X	X			X		
Age at diagnosis		X		X		X		X		
Race	X			X	X			X		
Spanish origin	X			X	X			X		
Sex	X			X	X			X		
Following physician	X									
Managing physician		X								
Primary surgeon	X									
Physician #3		X								
Physician #4		X								
Primary payer at diagnosis	X									
Usual occupation - text			X		X_2			X		
Usual industry - text			X		X_2			X		
Family history of cancer			X							
Tobacco history			X							
Alcohol history			X							
Type of reporting source			X	X	X			X		

ITEM	COC			SEER	NPCR			TCR		
	R	S	O		R	S	O	R	S	O
Date abstracted								X		
Abstracted by	X							X		
CANCER IDENTIFICATION										
Class of case	X					X		X		
Institution referred from		X								
Institution referred to		X								
Date of inpatient admission		X								
Date of inpatient discharge		X				X				
Date of Adm/1st Contact					X			X		
Inpatient/outpatient status			X							
Screening date			X							
Screening result			X							
Date of initial diagnosis	X			X	X			X		
Primary site	X			X	X			X		
Laterality	X			X	X			X		
Morphology/Histology	X			X	X			X		
Behavior code	X			X	X			X		
Grade/differentiation	X			X	X			X		
Primary site documentation - text						X		X	X_6	
Morphology documentation - text						X		X	X_6	
Diagnostic confirmation	X			X	X			X		
Tumor marker #1		X		X						
Tumor marker #2		X		X						
Tumor marker #3		X		*						
Presentation at cancer conference		X								
Date of cancer conference			X							
Referral to support services		X								
STAGE OF DISEASE AT DIAGNOSIS										
Size of tumor	X			X		X		X		
Extension (SEER EOD)		X		X						

ITEM	COC			SEER	NPCR			TCR		
	R	S	O		R	S	O	R	S	O
Lymph nodes (SEER EOD)		X		X						
Regional nodes examined	X			X		X		X		
Regional nodes positive	X			X		X		X		
Site of distant metastasis #1		X								
Site of distant metastasis #2		X								
Site of distant metastasis #3		X								
General Summary Stage (SEER)	X_5				X			X_1		
Staging documentation - text						X		X	X_6	
Clinical T	X									
Clinical N	X									
Clinical M	X									
Clinical stage group	X									
Clinical stage (prefix/suffix) descriptor		X								
Staged by (clinical stage)	X									
Pathologic T	X									
Pathologic N	X									
Pathologic M	X									
Pathologic stage group	X									
Pathologic stage (prefix/suffix) descriptor		X								
Staged by (pathologic stage)	X									
Other T		X								
Other N		X								
Other M		X								
Other stage group		X								
Other stage (prefix/suffix) descriptor		X								
Staged by (other stage)	X									
Other staging system			X							
Type of staging system (pediatric)	X									
Pediatric stage	X									
Staged by (pediatric stage)	X									
TNM edition number	X									

ITEM	COC			SEER	NPCR			TCR		
	R	S	O		R	S	O	R	S	O
Date of first positive biopsy			X							
Diagnostic and staging procedures	X					X		X	X_6	
FIRST COURSE OF TREATMENT										
Date of first course treatment	X			X		$\#_2$		X		
Date of non cancer-directed surgery	X					$\#_2$				
Non cancer-directed surgery - summary	X					$\#_2$		X_4		
Non cancer-directed surgery at this facility		X								
Date of cancer-directed surgery	X					X_2		X		
Surgical approach	X			*		$\#_2$				
Surgery of primary site	X			X		$\#_2$		X		
Cancer-directed surgery at this facility		X		*		*				
Cancer-directed surgery documentation - text						X		X	X_6	
Surgical margins	X			*		$\#_2$				
Scope of regional lymph node surgery	X			X		$\#_2$				
Number of regional lymph nodes removed (examined)	X			X		$\#_2$				
Surgery of other regional site(s), distant site(s) or distant lymph node(s)	X							X		
Reconstructive surgery - first course		X		X		$\#_2$				
Reason for no surgery		X		X	X_2					X
Date radiation started	X					X_2		X		
Radiation - summary	X			X		$\#_2$		X		
Radiation at this facility		X								
Radiation therapy documentation - text						X		X	X_6	
Regional dose: cGy			X							
Number of treatments to this volume			X							
Radiation elapsed treatment time (days)			X							
Radiation treatment volume			X							
Location of radiation treatment			X							
Intent of treatment (radiation)			X							
Regional treatment modality			X							

ITEM	COC			SEER	NPCR			TCR		
	R	S	O		R	S	O	R	S	O
Radiation therapy to CNS			X	X		#$_2$				
Radiation/surgery sequence			X	X	X$_2$					
Radiation treatment completion status			X							
Radiation therapy local control status			X							
Reason for no radiation		X				#$_2$				X
Date chemotherapy started	X					X$_2$		X		
Chemotherapy - summary	X			X		#$_2$		X		
Chemotherapy at this facility		X								
Chemotherapy documentation - text						X		X	X$_6$	
Chemotherapy field #1			X							
Chemotherapy field #2			X							
Chemotherapy field #3			X							
Chemotherapy field #4			X							
Reason for no chemotherapy		X				#$_2$				X
Date hormone therapy started	X					X$_2$		X		
Hormone therapy - summary	X			X		#$_2$		X		
Hormone therapy at this facility		X								
Hormone therapy documentation - text						X		X	X$_6$	
Reason for no hormone therapy		X				#$_2$				X
Date immunotherapy started	X					X$_2$		X		
Immunotherapy - summary	X			X	X$_2$			X		
Immunotherapy at this facility		X								
Immunotherapy documentation - text						X		X	X$_6$	
Date other treatment started	X					X$_2$		X		
Other treatment - summary	X			X	X$_2$			X		
Other treatment at this facility		X								
Other treatment documentation - text						X		X	X$_6$	
Protocol eligibility status		X								
Protocol participation		X								
RECURRENCE										
Date of first recurrence	X									

ITEM	COC			SEER	NPCR			TCR		
	R	S	O		R	S	O	R	S	O
Type of first recurrence	X									
Other type of first recurrence(s)		X								
Date (s) of subsequent treatment(s) for recurrence or progression		X								
Type(s) of subsequent treatment for recurrence or progression		X								
Recurrence site(s)			X							
FOLLOW-UP										
Date of last contact or death	X			X	X			X		
Vital status	X			X	X			X		
Cancer status	X									
Quality of survival			X							
Reconstruction/restoration-delayed	X									
Following registry			X							
Follow-up source		X								
Next follow-up source		X								
Unusual follow- up method			X							
Cause of death			X	X	X			X		
ICD revision number			X	X		X				
Autopsy			X							
Commission on Cancer coding system-current	X					X				

[1] Required, regardless of whether AJCC is completed or not. Cases reported from a non-registry hospital will be staged by TCR staff based on documentation provided. If stage is completed by reporting institution, supporting documentation must be provided.

[2] Code only when available in record.

[3] Only if documented in record, pathological stage takes precedence over clinical stage.

[4] Non-cancer directed surgery required in the absence of cancer directed surgery.

[5] ACoS requires only in the absence of AJCC classification.

[6] Highly recommended from facilities with a documented data quality program such as one approved by the American College of Surgeons.

[#2] When available, central registries funded by NPCR may code available treatment data using either 1998 SEER or 1998 COC data items and codes.

Source: Comparison of Data Sets, ROADS Manual

TCR Cancer Reporting Handbook; and

NAACCR Standards for Cancer Registries Volume II, Data Standards and Data Dictionary, third edition.